EXHIBIT 8

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

GUSTAVO AGUILAR, Plaintiff,	)	
VS.	)	Case No. 4:16-cv-00118
ALLIANCE RESIDENTIAL, LLC, Defendant.	)	

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ORAL AND VIDEOTAPED DEPOSITION OF

SASHA R. IVERSEN, D.O.

APRIL 4, 2017

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ORAL AND VIDEOTAPED DEPOSITION OF SASHA R. IVERSEN, D.O., produced as a witness at the instance of the DEFENDANT, and duly sworn, was taken in the above-styled and numbered cause on the 4th of April, 2017, from 9:32 a.m. to 2:45 p.m., before Mona S. Whitmarsh, CSR, in and for the State of Texas, reported by machine shorthand, at the offices of the Daspit Law Firm, 440 Louisiana, Suite 1400, Houston, Texas, pursuant to the Federal Rules and the provisions stated on the record or attached hereto.

APPEARANCES

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EXHIBITS

REQUESTED DOCUMENTS/INFORMATION

NO. DESCRIPTION

1 See Page 34, Lines 5-23

2 See Page 99, Lines 23-25 through Page 100, Line 4

THE VIDEOGRAPHER: We are now on the record. This begins Session No. 1 in the deposition of Dr. Sasha Iversen in Case No. 4:16-cv-00118 styled Gustavo Aguilar versus Alliance Residential, LLC, pending in the U.S. District Court for the Southern District of Texas, Houston Division.

Today is April 4th, 2017, and the time is 9:32 a.m., Central Time. We are at the Daspit Law Firm in Houston. The court reporter and videographer are with Magna.

Will counsel, please, state their appearances and whom they represent.

MR. GREENE: Adraon Greene for Alliance Residential, LLC.

MR. McALPINE: Kiernan McAlpine for Plaintiff, Gustavo Aguilar.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

SASHA R. IVERSEN, D.O.,
having been first duly sworn, testified as follows:

THE REPORTER: Are there any stipulations?

MR. McALPINE: By the Rules.

MR. GREENE: No.

THE REPORTER: And signature of the

witness?
Would you like to read and sign your deposition?
THE WITNESS: Yes.
EXAMINATION
BY MR. GREENE:
Q Ma'am, can you state your full name for the record?
A Sasha R. Iversen.
Q And what does the "R" stand for?
A Ringdahl, R-i-n-g-d-a-h-l.
Q And you are a doctor, correct?
A Yes.
Q So I will assume you prefer "Dr. Iversen"?
A Yes.
Q Dr. Iversen, my name is Adraon Greene. You and I just met this morning, true?
A Yes.
Q And you understand you are here today to give some deposition based on a life care plan and your work and opinions regarding that life care plan, in the case of Gustavo Aguilar?
A Yes.
Q Now, based on your CV and the information that you have produced to us in response to the subpoena

duces tecum, I understand that you have been deposed quite a few times before?
A I have.
Q Okay. So I will just briefly go over the rules for a deposition just so that you and I are on the same page.
You understand that I am going to ask you questions, you are going to provide me answers to those questions, the court reporter is going to take down the questions and answers?
A Yes.
Q And I will ask that you let me finish my question before you provide your answer and I, in turn, will let you finish your answer before I move on to the next question, for the purposes of the court reporter. Okay?
A Okay.
Q You understand that you are sworn under oath, just as you would be in front of a jury?
A Yes.
Q If you need a break at any time, just let me know you need a break and we can take a break. The only caveat is if I have a question on the table, I just need you to answer that question for me. Okay?
A Yes.

Q What's your current address?
A My work address? Office address or home address?
Q Give me both.
A Okay. I practice at 14770 Memorial Drive in Houston, Texas 77079.
Q That is your work address?
A Yes, sir.
Q Home address?
A I live at 814 Ivy Wall Drive, Houston, Texas 77079.
Q How long have you lived in Houston?
A Since 2012.
Q And what do you do for a living?
A I am a physician.
Q What type of physician?
A I am a physical medicine and rehab physician.
Q Do you do anything other than perform work as a physical rehab physician?
A I do the life care planning work as well.
Q And the life care planning work is work that you are paid for by law firms to perform?
A For the most part, yes.
Q What do you mean "for the most part"?
A Well, I am paid directly through -- I am not

paid directly from the law firm. I'm paid by an entity that I am associated with, Physician Life Care Planning.
Q And how are you associated with Physician Life Care Planning?
A I am an associate physician, so I am basically a 1099 employee.
Q And what is an "associate physician"?
A I am not an employee of theirs, but I am associated with them in the physician role.
Q And is it part of your job function at Physician Life Care Planning to be involved in litigation matters?
A What do you mean by that?
I prepare life care plans for whoever is requesting them through Physician Life Care Planning, so mostly litigation.
Q What percentage?
A All of the life care plans that I have done, I believe, have been for some sort of litigation. I know that other physicians associated with them have done life care plans for other reasons.
Q Well, we are just talking about you today. So for you, it's 100 percent of your work with Physician Life Care Planning is litigation, right?
MR. McALPINE: Objection. Asked and

answered.
A Yes.
Q (BY MR. GREENE) 100 percent?
A I believe so. I mean, yeah.
Q I was just clarifying because he objected. That's all.
Now, this particular case, you were retained for a litigation matter, correct?
A Yes.
Q And how did you find out about this case?
A I was contacted by one of the case managers at Physician Life Care Planning.
Q Do you recall that case manager's name?
A No, sir, I don't.
Q So explain to me how that works, your understanding of how that works?
MR. McALPINE: Object to vagueness.
A So basically I --
Q (BY MR. GREENE) You understand what my question is?
A How I get a case basically?
Q Absolutely.
A So basically a law firm or entity will contact Physician Life Care Planning. They are in need of a life care plan. Physician Life Care Plan- -- Physician

Life Care Planning will then assign that specific case to a doctor in -- usually in that specific area. So if it's in Houston, usually they contact an expert in Houston.
I will be notified electronically and then, as long as I don't have any conflicts, I will go ahead with that case. And then scheduling of, you know, the patient appointment and everything is done as well.
Q Do you schedule the patient appointment?
A That is all done through Physician Life Care Planning.
Q And would that be the case manager who handles that?
A It's electronic, as well as the case manager, so it's -- you know, I put in my available dates and then the law firm will select what they would like.
Q And is that what happened in this case?
A Yes.
Q Do you know who contacted the case manager in this particular case?
A No, I don't.
Q Have you ever worked with Mr. McAlpine before?
A I don't believe. Maybe one case before. I don't recall. I don't know.
Q Do you recall working for the Daspit Law Firm

before?
A Yes, I think I have worked with them.
Q Did you work with him, Mr. McAlpine?
A I don't recall specifically.
Q Okay. How long have you been an associate physician at Physician Life Care Planning?
A Since 2014.
Q We are going to mark some exhibits to your deposition. First one we are going to mark is your notice of deposition -- actually, the renotice of deposition, we will mark this as Exhibit No. 1.
(EXHIBIT 1 WAS MARKED.)
Q (BY MR. GREENE) And I have to apologize to you because this identifies you as "Sarah Iversen" as opposed to "Dr. Sasha Iversen," but that's that.
And the next thing we are going to mark is a subpoena duces tecum. Do you recall receiving a subpoena in this case?
A I don't know if I have seen the subpoena. I believe I received it, but it might have been through Physician Life Care Planning. I have just seen this, actually.
Q So you have never seen the deposition notice before today?
A I did see the deposition notice, this one, but

I don't recall seeing that portion of it.
Q Oh, no, no, no. I apologize if I am confusing you.
We served a subpoena on you prior to the deposition notice. Do you recall that?
A I believe I have seen it. I just -- I don't -- I haven't seen it recently so...
Q Let me back up a little bit. Before coming in here today, did you meet with Mr. McAlpine to prepare for your deposition?
A No.
Q Did you review any documents to prepare for your deposition?
A Yes, I did.
Q What did you review?
A I have a list of everything that I have reviewed. So obviously all the documents listed in my life care plan were reviewed, and then we were provided with subsequent documents after the life care plan was completed. So there is a list of those as well.
Q Let me see that.
A (Witness tendering.)
MR. McALPINE: Can I see that when you are done?
MR. GREENE: Sure.

Q (BY MR. GREENE) And the life care plan that you handed me is dated December 1, 2016?
A Yes, sir.
Q That's the same one that was produced in this case, as far as you are aware?
A Yes.
Q There you go. You can have that.
And you have also produced, or you have handed to me, what's marked -- we will mark this as Exhibit No. 2.
(EXHIBIT 2 WAS MARKED.)
Q (BY MR. GREENE) And this is the complete list of documents that you have reviewed in preparation for your deposition today?
A In addition to -- yeah, so together they will be the complete list.
Q And this is an 11-page document, right?
A Yes.
MR. GREENE: On a break, can I get a copy of that?
MR. McALPINE: Sure. Yeah, I need one, too.
MR. GREENE: Not front and back. And actually, we will mark the one that's not front and back as Exhibit 2. That will assist the court reporter in

copying it.
Q (BY MR. GREENE) All right. Are there any documents in Exhibit No. 3 that in any way change any of your opinions?
A I don't know specifically. That's kind of a broad question.
Q Okay. Let me ask you a different way: You authored your report on December 1st, 2016, correct?
A Right.
Q Have you authored a supplemental report?
A No, I have not.
Q Do you plan on offering a supplemental report?
A I have not been asked to do that. I have contemplated doing that because, in addition to the life care plan that was done, I also got the chance to see Mr. Aguilar in person while he was admitted at a facility. So I had not had the opportunity to do that prior to the life care plan being completed.
Q So if I understand your testimony, you did not conduct an examination of Mr. Aguilar prior to authoring your report?
A No. We had one scheduled and then because of Mr. Aguilar's condition, he was not able to make that appointment. And the life care plan deadline date was still on so -- and, you know, sometimes I will do that.

If -- if -- I will include everything except the exam. Obviously I like to have the exam as well, but I can do it without.
Q So the answer to my question, though, is your life care plan that you wrote in December, 2016, you did not rely on the exam to formulate any of those opinions; is that true?
A Correct.
Q All right. And there is another document that you have been pointing to, that's sitting down in front of you. What is that document?
A This is basically my summary of my visit with Mr. Aguilar.
Q Can I see that?
A Yes (tendering).
Q And have you ever given this summary to Mr. Aguilar's lawyers before today?
A No.
Q Why not?
A I wasn't asked for it, and basically I -- I guess I wasn't asked for it until -- I assumed I would bring it to deposition. That's normally what I do, if there is any extra documents.
Q Well, you do -- we will mark this one as Exhibit No. 3.

(EXHIBIT 3 WAS MARKED.)
MR. GREENE: And I will need a copy of this, too, on the break.
MR. McALPINE: Sure. I would like to read this.
Q (BY MR. GREENE) Exhibit No. 4 we are going to mark as the subpoena that I referenced earlier.
(EXHIBIT 4 WAS MARKED.)
Q (BY MR. GREENE) And the subpoena contains an Exhibit A that required you to produce certain documents. Okay? If I understand your testimony, you did not see Exhibit 4, or you have not seen Exhibit 4 before today, have you?
A I believe I have. It wasn't included in the most recent things that I have reviewed, though. But I do have, you know, all my file with me today.
Q So you brought your entire file with you today?
A Yes, I did.
Q Can you get that out for me?
A Yes. I have -- I have some handwritten notes from when I actually saw Mr. Aguilar, and then I have a USB drive which contains all the invoices and any other documents basically. So it's all in here.
Q Okay. The information on that USB drive, has

it been given to your lawyer -- to Mr. Aguilar's lawyers before?
A No. I prepare it, like, before I go to deposition.
Q Let me see that subpoena, Exhibit --
MR. McALPINE: I mean, you have got a bunch of documents in response to the subpoena already.
Q (BY MR. GREENE) So Exhibit No. 4 is the subpoena. You understand this is the subpoena that was handed out pursuant to the lawsuit that was filed, and you are required to comply with it, yes?
A Yes.
Q And this was sent to you, yes?
A It's sent to Physician Life Care Planning usually.
Q No. This is sent to Dr. -- to Sasha Iversen, D.O., 1321 Park Bayou Drive, Houston, Texas, or --
A That's --
Q -- 814 Ivy Wall Drive, Houston, Texas.
Have you ever lived at either of those addresses?
A Yeah. 814 Ivy Wall, yes.
Q So this was sent to you, not to Physician Life Care Planning. Do you understand that?
A Yes, I did get that actually at my house. I

remember now. I got it at my house a while back, and then I forwarded it on to Physician Life Care Planning, because they will help me kind of send any documents on.
Q This was served on December 30th, 2016.
A December 30th?
Q Yes, ma'am. Date (indicating). Not that you received it on that date, but --
A Yeah. I wasn't --
Q -- that's the date it was served.
A -- there on that date.
Q Okay. And it commanded that you provide documents to us, the defendants, the defendant's attorneys, by January 10th, 2016, [sic] at 4:00 p.m.
Whether you met that deadline or not, you did supply us with documents, right?
A Right.
Q The documents that you supplied us with were in response to Exhibit A, true?
A Right.
Q And you understand that based on the subpoena, everything that was in your possession at the time, you were supposed to give to us, right?
A Correct.
Q You understand that you have a continuing duty to supplement this and give us any additional documents,

right?
A Yes.
Q Okay. You haven't done that until today, though, have you?
A Let me clarify something.
I didn't see Mr. Aguilar until after the subpoena was served, and I also didn't receive subsequent documents until February of this year, so everything that I had in my possession was supplied to you.
Q But before today, you didn't supplement with any of that information; is that right?
A No, and I typically do not do a supplemental report, because that's an extra cost to the attorneys, so I will not just do that, unless I am requested to do so.
Q Well, did you advise the attorneys that you had additional documents that were responsive to Exhibit A of the subpoena?
A Usually -- I don't see what the issue is, because usually I will bring those things to depositions. They know that I have seen the individual.
Q No, no, I understand what you usually do, but my question is: For this case, did you provide the attorneys, Mr. Aguilar's attorneys, with the

supplemental information that you either received or created after you initially responded to the subpoena?
MR. McALPINE: Objection. Argumentative, misleading. The witness is complying with her duty to reasonably, promptly supplement.
A So I can --
MR. GREENE: All you have to do is object, thank you.
A I do -- I can let you know that I finished the physician consultation final yesterday, as well as the record review. I received the final yesterday, so I did let Mr. McAlpine know that I will be bringing those things with me today.
Q (BY MR. GREENE) And what is the "physician review"?
A This is the physician consultation, my final copy of my notes with him. Obviously, I make notes, do a dictation, and then, you know, work on it. And then the medical records review as well.
Q And you are talking about Exhibit No. 3 is the --
A Two and --
Q -- physician consultation, right?
A Yes.
Q When did you perform this physician

consultation?
A I interviewed and examined Mr. Aguilar January 26, 2017.
Q And did you obtain any information based on this physician consultation that changes any of your opinions in your report from December 1st, 2016?
A Again, I -- since I did get the opportunity to examine him after my life care plan was done and review subsequent records, I do believe that there will be a few changes to the life care plan, and we did talk about a possibility of a supplemental report. However, again, I don't -- you know, I don't just go and do those without being asked to do so, but I do think there will be some changes.
Q What changes do you anticipate making?
A I can -- do you want me to go through the whole thing and...
Q No, no.
A Okay.
Q Just sitting here right now --
A Oh, okay.
Q We will get to your report.
A Yeah, okay.
Q But they are not in your report now, so I'm wondering --

A Correct.
Q You are sitting here and you just told me that you do anticipate --
A So basically --
Q Let me finish, please, ma'am.
A Sorry.
Q Thank you.
You anticipate making a few changes, so you have already contemplated that. Tell me what you have contemplated.
A So, broadly, without going into detail, when I saw Mr. Aguilar, he is at a level of disability currently that I did not -- that was not impressed upon me based on the initial records. And due to his comorbidities, including ankylosing spondylitis and a subsequent injury that he sustained, I am going to decrease the life expectancy in my report.
Q Anything else?
And we'll talk -- I'm sorry. Let me interrupt you real quick. We will talk about the specifics of what you are going to change --
A Okay.
Q -- when we go through the report.
A I believe that's generally the biggest change that I will be making.

Q And you are decreasing the life expectancy because of the ankylosing spondylitis?
A The comorbidities, the subsequent injury that caused him to be -- to have further paralysis of his upper extremities, as well as the ankylosing spondylitis, and his general medical and rehab potential.
You know, when I saw him, basically he is -- he is bed-bound now. He is going to have -- he is going to have, you know, specific complications likely due to his immobility, which will, in turn, cause him to have a decreased life expectancy, in my opinion.
Q And when is the first time that you told Mr. McAlpine about your desire to provide a subsequent life care plan that would decrease his life expectancy?
A He requested a call yesterday, and I expressed that to him on the phone yesterday.
Q Okay. So you didn't meet with Mr. McAlpine before your deposition, but you did talk to him?
A Yes.
Q When did you guys talk?
A Yesterday around 5:15 or so, p.m.
Q For how long?
A About half an hour.
Q What did you guys talk about?

A He asked me what records I had, what records I had reviewed, if I had any changes to my report, and then basically, you know, confirmed where I was going to be meeting him today.
Q And how does decreasing the life expectancy in the report affect your ultimate opinions?
A Basically, in my opinion, he will need the same things that I have outlined in this life care plan. None of the actual items are going to be taken out, but because I am decreasing the life expectancy, the overall future medical costs are going to go down obviously, because there is fewer years that he is going to need to be covered.
Q The number will go down?
A Right.
Q And when you saw Mr. Aguilar in January of 2017, how did you describe his condition?
A I saw him at a subacute rehab facility in Pasadena. He is basically -- he is awake, alert, oriented. I mean, you can read my physician consultation, but he is actually not able to feed himself, at least when I saw him.
He needs 24-hour care for positioning for -- you know, his only -- when I -- you know, what he reported to me was his only kind of activity right now

is being picked up and put in a chair for, you know, maybe an hour every day and then put back in bed.

He needs full assistance for any type of, you know, cleaning or bathing or anything like that, so he is 24-hour care right now. He is unable to do anything. He couldn't even reach his cell phone so...

Q And on December 1st, 2016, does your report reflect that level of care --

A No.

Q -- your life care plan?

A No, because I -- I basically had all these initial records from the injury in 2013, and I was aware that he had had a subsequent injury, because that's why he had missed his appointment to see me in the office. So I did kind of get some information as far as, "Okay. He had his accident. He is a little worse. He had cervical injuries," but I didn't have any specific detail about his function.

And, obviously, you know, when you see somebody in person, it's different than if you are just reviewing a few records. So after seeing him, it was clear to me that he is going to need much more assistance than what I originally put in the life care plan, but what I put in the life care plan is related to the injury that -- that initial injury. I didn't

outline, you know, 24-hour care, for example, for the rest of his life. I did less than that, because, basically, you know, after this accident he was paraplegic. He was, from the waist down, paralyzed.

Q Okay. And let me clarify what you just said.

When you say, "after this accident," you are talking about the October 11, 2013, accident, correct?

A Yes, sir.

Q After the October 11, 2013, accident, he was paralyzed from the waist down?

A Correct.

Q And then you said he had a subsequent accident, correct?

A Correct.

Q And you said, based on that subsequent accident, your words, he was a "little worse" now than he was after the October 11, 2013.

Do you recall saying that?

A Yes. That's one of the things I said --

MR. McALPINE: Objection. Misstates.

A -- but I also said he -- he -- you know, he basically can't feed himself. I went through a whole set of examples.

Q (BY MR. GREENE) Right. And that's -- he is more than a little worse, right?

A He is basically quadriplegic or tetraplegic now. He was paraplegic before.

Q Okay.

A So the things that go along with those specific diagnoses, yes. But, again, you know, the things that I outlined in my initial life care plan, I did basically outline the things that, in my opinion, were going to be treating that initial injury.

Q Okay.

A Obviously, there is some overlap in a spinal cord injury, but, you know, if I -- my -- the best way to explain that is I didn't put him at 24-hour care, for example, which is actually what he is going to need, but I am saying, based on that initial accident in 2013, he will need some care.

Q Right. If I understand your testimony, 24-hour -- the 24-hour care that you are saying he currently needs is not related to the initial accident on October 11, 2013?

A No. I believe he will need less than -- I believe he will need some care, which I have outlined, but obviously he will need above and beyond what's going to be in the life care plan.

Q My question, though: As a result of the October 11, 2013, incident, in December of 2016, did you

opine that he needed 24-hour care?

A No. I said eight hours a day. And then, you know, with a spinal cord injury, as you age, you are going to need more and more care.

Q Let me hand you back Exhibit A.

A Uh-huh.

Q And Exhibit A is part of Exhibit No. 4, the subpoena. In response to Exhibit A, you produced a file to us.

Do you remember that?

A The -- which file? Well, yes.

Q Well, the documents --

A The USB? The USB drive or the...

Q I don't know what's on the USB drive so I can't -- I don't know.

A Oh, you are saying, "initially." I'm sorry. Yes, yes.

Q In response to the subpoena and in response to Exhibit A, you produced a file to us, which I am holding right now, and we will mark this entire file as Exhibit No. 5. Okay?

A Okay.

(EXHIBIT 5 WAS MARKED.)

Q (BY MR. GREENE) And we are going to go through the file, and what I am going to do is mark exhibits

contained in the file as separate exhibits for us today.
A Okay.
Q All right?
The first thing that you produced -- and we will mark it as Exhibit No. 6 -- is your CV.
(EXHIBIT 6 WAS MARKED.)
Q (BY MR. GREENE) Does Exhibit No. 6 fairly and accurately reflect your CV?
A Yes. There was a change, actually. There was an error that I found a while back, if I can -- well, I will just tell you. So under "Specialties," I am currently going to sit for the pain medicine boards. That should be integrative medicine, integrative holistic medicine. So in my -- the first page, do you have the first page there?
Q Yes.
A So -- of my bio? Do you have my bio?
Q I do not have the bio in front of me, no.
A So basically I am board certified in physical medicine and rehab and integrative holistic medicine and life care planning, and I am not currently certified in pain medicine. I am sitting for the boards in a couple of months, so that's the only change.
Q All right. The next thing that you produced in response to the subpoena, we will mark it as

Exhibit 7.
(EXHIBIT 7 WAS MARKED.)
Q (BY MR. GREENE) It's a case list. Is that the case list that you produced in response to the subpoena?
A Yes, sir.
Q Okay. Let's go back to your CV really quickly. Is there anything else on your CV that's not current?
A The only additional thing would be on Page 2. I also was participating in the board examiner role for 2014, 2015, and 2016, so that wasn't updated at the time you had -- at the time you got this.
Q I'm sorry. And where does that belong on Page 2?
A Under "Noteworthy Professional Contributions," I was also doing the American Osteopathic Board of Physical Medicine and Rehab observer for future oral board examiner role from -- in October, 2014, 2015, and 2016. So I have done it for the past three years. Otherwise, everything is up to date.
Q And when was it prepared? When was your CV prepared?
A We update it, like, all the time. So this would have been probably end of 2016 sometime.
Q Do you know for sure when it was prepared?

A No, I do not.
Q But you think it was probably prepared at the end of 2016?
A I mean, it was prepared, you know, back in 2014, and then I constantly add things to it so...
Q Okay. When is the last time it was updated?
A I am not sure the exact date of that, but the last time this copy was updated was sometime in 2016. I have updated it. And that's actually on the USB drive, so it has the changes that I talked about.
Q So on the USB drive, there is an updated version of your CV?
A Yes, sir.
Q And it contains the information that you told us -- told me about earlier today, correct?
A Yes, sir.
Q What's the last thing you added to your CV that's in front of you here?
A It was the change for the board certification and then adding on the board examiner role.
Q I'm sorry. My question wasn't clear. I'm sorry.
Not your current CV. The CV that you produced in response to the subpoena, what was the last thing you added on to that CV, which is marked as Exhibit No. 5?

A Maybe I am not understanding you. I would say the board examiner role. I have done it the last three years, so that was the last thing I added on.
Q Okay. When was your last publication?
A Probably back in 2012. I was -- 2012, 2013, I was contributing -- an author -- a contributing author to several books that, during my residency, I was a part of.
Q And if we look at the first page of your CV -- I'm sorry, second page of your CV -- your "Professional Appointments," are those what most people commonly refer to as their jobs right now?
A Yes.
Q All right. And currently, as you said, you are an associate physician at Physician Life Care Planning, right?
A Yes, sir.
Q All right. And did you explain -- tell me all the duties and responsibilities you have as an associate physician at Physician Life Care Planning.
A Basically, I am available for life care plans and the preparation of those life care plans, as well as expert witness duties, which usually tie into the life care plans.
I have been retained by, you know, a few

defense attorneys for, like, reviewing other life care plans or just reviewing documents and doing kind of a record review, but not for life care plans so... Expert witness, as well as life care planning.

Q Have you ever been retained by a defense firm to write a life care plan?

A No, I have not. Well, actually, yes. I take that back. One time I have. Normally, it's just reviewing others', but I did do a life care plan for the defense.

Q When -- well, we will get to your -- is it on your --

A No. This is just my testimony list that you have here, but I don't have a case list of all my plans. But I did it probably end of 2016.

Q What was the defense firm?

A It was somebody in Dallas. I'm sorry. I don't remember the name.

Q What was the name of the case?

A I can get that for you. I am not sure of it.

Q What we will do is leave a blank in your deposition so you can fill that in when you read and sign it.

(REPORTER'S NOTE: The Witness will please include this information on the errata sheet when she

reads and signs the deposition.)

A Okay.

Q (BY MR. GREENE) But as I understand it, there is one defense firm and one defense case that you were retained as a life care planner?

A Yes, sir.

Q And did you actually author a report?

A Yes.

Q We will also leave a space in the deposition for the name of that defense firm. Okay?

A Okay.

Q Now, as a consulting physical medicine and rehab physician, general --

A General, musculoskeletal, and neuro-rehabilitation.

Q Yeah, thank you.

The "post-acute rehabilitation facilities," what is that?

A So basically I have an office practice where I see people who have rehabilitation needs, so anybody with injuries or pain or post-orthopedic injuries. So that's in the outpatient setting. And then I also go to post-acute facilities. So "post-acute" just means they are out of the hospital.

So either they go -- you know, an example is

the facility that Mr. Aguilar was in when I saw him -- I saw him at -- you know, I wasn't treating him then, but those are the types of facilities where I will go see patients on consultation, so I go to two or three facilities here in Houston and do PM&R consults and am involved in their rehabilitation care and their discharge planning, et cetera.

Q All right. So --

A So it's both the inpatient -- in a post-acute, inpatient and then outpatient.

Q How many patients do you currently treat?

A I don't have like a -- I don't keep a running number, but I have, you know, I would say, like a part-time practice, office -- split between the office and the facilities. And then I also am supervising a nurse practitioner who helps me in the facilities as well.

Q Let me ask you a different way: Do you treat any patients currently?

A Yes, sir.

Q Give me an estimate of how many patients you currently treat.

A You know, every week is different. It depends on if I get consults or if they need follow-up, so I don't know if I can really give you a number.

Q Is it more than ten?

A Yes.

Q Is it more than 20?

A I would say per week it's probably between 10 and 20 patients, depending on if it's follow-ups and then I also am oversighting patients through a nurse practitioner, so that's, you know, 50 to 100 patients per week as well as, you know, reviewing all the records of people that are on the home health, because I also am a part of that as well.

Q Well, right now, I am just limiting it to your work in PM&R. Okay?

A This is all PM&R, yeah.

Q All of it?

A Yeah, yeah, all of it is PM&R.

Q So the biggest number I heard you mention was 100?

A Right. Through my nurse practitioner and the home health and we have -- we have a pretty big caseload. I mean, I can't -- that's why it's hard to break up week per week because some of these patients we have been following for a couple of years so -- and they may not need something now, but they may need something in a couple of months. And if they need prescriptions or devices or anything, that's who they call is me.

Q So you actually write prescriptions for devices for these patients that you see?
A Yes, sir, and medications as well.
Q And what does your treatment of these patients include?
A Physical medicine and rehab is a very diverse specialty, so it will be younger patients who need, you know, pain medication or devices or prescriptions for therapy because they have had injuries, like workers'-comp-type patients, up, you know -- and then when you go to facilities, it's people who either have, like, elective orthopedic procedures or they were just in the hospital and they are severely debilitated and they need rehabilitation before they can go home. Or if they can't go home, they are going to go to whatever facility. So I will help transition them to whatever facility or home or whatever level of care is going to be the best and safest for them.
I think I answered you but...
Q You kind of got lost in your answer, too?
A Yeah.
Q Post-acute rehabilitation facilities, is that more than one facility?
A Right. I go to -- it changes all the time, but there is about three that I go to now and, you know,

I am probably credentialed at, like, five different ones. It just depends on when I get consults.
Q And what does this title mean: "Consulting Physical Medicine and Rehabilitation Physician"?
A Basically they have their medical doctor -- you know, their internist or their family doctor -- treating their hypertension and their -- most of their medication needs. I will assist with the physical therapy, occupational therapy. I will oversee those individuals, so I am kind of oversighting the rehabilitation.
And I am a consultant, because I am not their -- I am not going to be the one discharging them from the facility, for example, but I am the one who is -- they will call me if, like, somebody is not making progress in rehabilitation or in PT and OT, if I have any suggestions, or if they need medication changes for, you know, poststroke treatment, because I have the expertise to treat the spasticity and treat the comorbidities of stroke as well because, again, PM&R is a very broad specialty.
So anything from, you know, neuro-rehab like a stroke and TBI, to post-orthopedic to, you know, nonsurgical interventions for orthopedic, injections and things like that.

Q What is the difference between "PT" and "OT"?
A So "PT" is physical therapy. It focuses on ambulation and more the gross motor movements. Walking, transfers, maybe, you know, some type -- sometimes they will help with bracing of the lower extremities.
And then occupational therapy is more fine motor movements, upper extremity. Also the OT is the individual who is going to assist with any type of device for ADL, activities of daily living, so they are more focused on ADLs and upper extremities.
And then speech therapy --
Q I didn't ask about speech.
A No. I just want to say that that's one of the other things that I oversight so --
Q Okay.
A -- that's --
Q Speech therapy has nothing to do with this case, though, does it?
A Only the cognitive aspect. I did recommend he have an evaluation, so that's -- you are correct.
Q Okay.
A I just want to kind of go over, that's also what I do.
Q All right. Now, you mentioned your specialties earlier. Were you mentioning specialties or

board certifications?
A Board certification.
Q So do you have any subspecialties?
A No. I am board certified in physical medicine and rehabilitation.
Q I understand that, but you don't have any subspecialty certifications, do you?
A No. I chose not to complete a fellowship, so I just did the four years of physical medicine and rehab residency and then did my boards after that.
Q Now, is there a subspecialty certification in spinal cord injury medicine?
A Yes. There are several subspecialties in PM- -- under PM&R.
Q But in this particular case, Mr. Aguilar suffered from a spinal cord injury, correct?
A That's correct.
Q All right.
A And, again, just to be clear, a physical medicine and rehab physician, a general PM&R, we treat spinal cord injury. Obviously, you know, in the last few years now, they have had -- now they have fellowships and now they have, you know, doctors who only want to do spinal cord injury and they will go ahead and do the fellowship and do the boards in that.

Q All right. Let me see that, please (indicating).
A (Witness tendering.)
Q Thank you.
I want to show you what's been marked as Exhibit No. 7. And I think I called it a "case list" earlier, but you said you don't maintain a case list, correct?
A Correct -- excuse me. Correct.
Q What do you maintain?
A This is the list I maintain, the depositions --
Q Right. What is it?
A The depositions and court appearances.
Q And is that list current?
A No. I have brought a current one with me today.
Q Okay. So today you brought another case list, and we will mark this as Exhibit No. 8.
(EXHIBIT 8 WAS MARKED.)
Q (BY MR. GREENE) Can I see Exhibit No. 7, please, ma'am?
A Yes (tendering).
Q I mean, when you compare Exhibit 7 to Exhibit 8, it looks like you added four more cases,

right?
A I believe so. I would have to double-check.
Q So this is only a list of depositions and court appearances, true?
A True.
Q What is not included on this list, in terms of the litigation work that you do?
A I mean, all the life care plans that I have done is not included or any time I have been retained as an expert, just on a case where I didn't do a plan.
Q For our purposes today, is it better that we use Exhibit No. 8?
A It's more current.
Q Okay. Now, you mentioned a Dallas firm that retained you in 2016. That Dallas firm is not on this list; is that correct?
A Yeah, it's not because it was -- I was not called for a deposition or trial.
Q So all the law firms on Exhibit No. 8 are all the plaintiffs' law firms, right?
A That's correct, yes.
Q And all of the individuals identified in Exhibit No. 8 are all plaintiffs, correct?
A I believe so. I think it has a...
Q Well, there is no way to tell on here, unless

you can...
A I think... No, they are all plaintiff, yes.
Q Okay. So you have never given a deposition on behalf of a defendant --
A I have never --
Q -- related to a life care plan that you wrote?
A I have never been asked to do so, so, no, I have not.
Q So you have never given a deposition on behalf of a defendant --
A That's correct.
Q -- related to a life care plan that you wrote?
A That's correct.
Q All right. And you have never made a court appearance on behalf of a defendant for a life care plan that you wrote, correct?
A Correct.
Q And I see that you have been to trial twice.
A Yes.
Q The Ella Williams case -- and the date that you have here is October 26, 2016 -- was that a state court trial or a federal trial?
A State.
Q Did you actually testify?
A Yes, sir.

Q And the next one you have, January 11, 2017, Stephen Land. That's also a trial. Was that a state trial or a federal trial?
A State.
Q State court?
A I believe so, yeah. That was at the same courthouse, so I think it was -- I believe it was both state.
Q And both times you were retained by Pierce, Skrabanek & Bruera, right?
A Yes.
Q You do a lot of work for Pierce, Skrabanek & Bruera, correct?
MR. McALPINE: Object to form.
A Yeah, they have used me several times.
MR. McALPINE: Vagueness.
Q (BY MR. GREENE) Now, you told me about -- would it be safe to say your "clinical work"? Is that --
A Yes.
Q -- a fair estimation or fair characterization, rather?
A Yes.
Q All right. What percentage of your work is spent on lawsuits or litigation matters?

A I would say it's about 50 percent doing the litigation work.
Q So is your practice 50 percent litigation, 50 percent clinical?
A Right.
Q And with respect to it being 50/50, is that on a yearly basis or a monthly basis? What is your estimate for that?
A I mean, it's just an estimate. I think now it's probably been a little bit less litigation but, like, the beginning of the year, I had several depositions, that you can see on that list. So maybe it was, you know, more close to 50/50, because I had, like, two or three right in a row. So I would say, on a yearly basis, it's 50/50. Monthly, it's kind of hard to say. It fluctuates.
Q And is all of the litigation work through Physician Life Care Planning?
A I do see patients for treating. I see a few patients that I am paid directly through the law firm, but that is -- so that's not related to Physician Life Care Planning. I have a few clients that have contacted me through -- just directly to say, "Can you treat this individual as their treating doctor?"
Q Right. I am not talking about your -- okay.

A So that's kind of --
Q Well, let me ask you -- let me ask you this way: When you say you're a treating doctor -- as a treating doctor, you are referring to your clinical practice, right?
A Right.
Q Okay. I am talking about your litigation practice.
A Okay.
Q So all of your litigation and lawsuit matters, do they come from Physician Life Care Planning?
A Yes, I would say that's true.
Q And on your list, the first one here is dated August 26, 2015, Mario Ibarra, from and Simon O'Rourke Law Firm.
A Yes.
Q Is that the first life care plan that you wrote?
A I don't believe it was the first life care plan I wrote. That was the first deposition that I had.
Q Okay. When did you first start writing life care plans?
A When I started working with Physician Life Care Planning --
Q 20- --

A 2014, yeah.
Q And so according to this, you have taken -- you have given, rather, 26 depositions. Does that sound about right?
A Sounds a little high, but I don't know if that would be -- did you count the trials, too, or just the --
Q No. I just counted --
A Okay. Yeah, I think that's about right. I know it was --
Q I will count them again.
A -- low 20s. Yeah, low 20s.
Q Well --
A Some of the depositions were, like, two cases on the same day, so I don't know if you want to count that twice or not but --
Q No. I am counting each one that you list so --
A Yeah.
Q -- it was 23 on this list.
A Yeah.
Q Let me count again for the sake of --
A Oh, I was just saying that --
MR. McALPINE: What about today?
A -- there were a few cases that basically they

took my deposition on the same day for two different cases, so that's -- 26 sounds about right.
Q (BY MR. GREENE) Based on Exhibit No. 8, you have been deposed 26 times before today?
A The list is correct so...
Q All right. Have you ever been deposed for any reason that is not reflected on this list -- excuse me -- that's not reflected in Exhibit No. 8?
A No, sir.
Q And all 26 of these depositions have been for plaintiffs' firms, right?
A Yes.
Q And you have been to trial twice, correct?
A Yes.
Q 100 percent of those trials were with plaintiffs' firms?
A Yes.
Q All right. Do you maintain copies of your depositions?
A No. I don't keep them. I usually just send them back. If I -- if I do read and sign, then I will send them back, but I don't keep copies.
Q Do you maintain copies for cases that are still pending?
A Again, I typically just will receive the

deposition and then send it back.
Q Okay. So you don't --
A Yeah. I don't keep -- yeah. I can't, like, keep -- I don't have the space.
Q So for your trials, when you were getting ready for those trials, did you review your depositions to prepare for the trials?
A Yeah. I mean, they are all -- so we have like a database or like an online software that we use, like a cloud-based software, so anything that I need, I can just kind of get from there and then review it, but I don't keep any of it, if that makes sense. It's all available, but I don't -- I don't keep, like, copies of everything.
Q Who is "we"?
A Physician Life Care Planning.
Q So there is a -- what did you say? There is a database?
A It's like an online software that they have developed specifically for their company, so basically all the communication is done through that online system. And then, like, the attorneys can upload documents, I can download documents, I can up- -- you know, I can do my changes and things like that, so everything is online.

Q All right. So your depositions that you have given would be kept online with Physician Life Care Planning?
MR. McALPINE: Objection. Mischaracterizes --
A Possibly --
MR. McALPINE: -- testimony.
A -- because it's -- you know, if they have been uploaded or if I have done depositions. I don't -- but, again, like, if I have a trial -- like, the one trial, I had not actually been deposed. Actually, neither one of the -- the Ella Williams case, I had not been deposed, so I didn't have to review any deposition.
The Stephen Land, I don't recall if I actually had done a deposition for him either, so I don't know if I have been in that position. I know -- you know, I obviously review my life care plan or whatever documents I am provided with.
Q Do you know whether Physician Life Care Planning has a database that stores your depositions from previous --
A I don't --
Q -- cases?
A I don't believe they do. It's basically they have the individual involved in the case and then

whatever people have uploaded for that case so...
Q Who would be the person at Physician Life Care Planning that would know that?
A Probably any number of people.
Q Well, who is the person you deal with mostly?
A I deal with different case managers for different cases so...
Q Who is the case manager in this case?
A It is Rebecca.
Q Rebecca what?
A Pese, P-e-s-e.
Q P-e-s-e?
A Yes.
Q And is she the case manager that you were referring to earlier in your testimony, with respect to intaking the call from the Daspit Law Firm or whoever regarding Mr. Aguilar's case?
MR. McALPINE: Objection. Calls for speculation.
A Right, yes.
MR. McALPINE: Mischaracterizes prior testimony.
Q (BY MR. GREENE) Other than Rebecca Pese, tell me the other folks at Physician Life Care Planning who are case managers.

A There are several of them. I mean, I'm not --
Q Right. Tell me the ones that you remember.
A Do you want, like, a list of --
Q Yes, I do.
A Okay. I do not have their last names committed to memory.
Q Well, I tell you what: Tell me the ones who you remember. If you remember the last name, provide me with the last name. If you don't remember the last name, just give me the first name.
A Okay. I mean, I have Lauren, I have Rebecca, I have --
Q Is that a different Rebecca or the same Rebecca?
A No. It's the same Rebecca. There is about three that I deal with. There has been some changes, so I don't know if...
Q That's a good point.
A Yeah.
Q You deal with about three case managers?
A At a time, yeah. Like, ongoing it's usually about three. Oh, Jenny is another one.
Q And do you know Jenny's last name?
A No, I don't know.
Q Do you know Lauren's last name?

A No. I just -- I will just ask for Lauren or Jenny when I call them or e-mail.
Q When you e-mail them, is there a last name included in their e-mail address?
A I think there is, but it just -- you know, it just pops up.
Q Autofill?
A Yeah. It's not something I need to commit to memory so...
Q Now, and the folks identified on Exhibit No. 8, did any of these people suffer injuries similar to the ones Mr. Aguilar suffered in this case?
A Can I see it, please?
Q Sure (tendering).
A I don't recall specifically if anyone had the same injuries as him. I know that I don't think I have done a life care plan with somebody -- for somebody with ankylosing spondylitis before. I have obviously, you know, treated patients with spinal cord injury.
And one of the main areas of expertise in -- within PM&R is, for example, like our board exam is, like, 30 percent spinal cord injury so -- and then 30 percent stroke and so it is one of the main areas of my specialty, but I don't know if I have done a -- well, I don't know if I have had a deposition. I have done life

care plans for individuals with a spinal cord injury.
Q But no one like Mr. Aguilar; is that fair?
A I don't know what you mean by that. I mean, I have done life care plans for individuals with spinal cord injury, and I have treated patients with both ankylosing spondylitis and spinal cord injury. And obviously nobody is going to be just like Mr. Aguilar so...
Q My initial question: Are there any people identified on Exhibit No. 8 who suffered injuries similar to Mr. Aguilar? That's where we started.
MR. McALPINE: To the extent it's not -- objection. To the extent it's not asked and answered, the question is vague.
A So I would say, "yes," there are people that I have done life care plans and that I have been testifying for that have similar injuries, but I don't remember who, because some -- like, for example, some of these people -- I don't know. I think it was Mr. Cepeda, with a "C," I mean, he had a little bit different injury but severe traumatic brain injury, bed bound, full care, and I think he had spinal fractures as well. So he had kind of a dual injury, but the same level of disability essentially so...
Q Right, but do you --

A I don't recall. I can't -- I'm sorry. I don't recall.
Q So that's a fair answer. You don't recall anyone on this list having injuries similar to Mr. Aguilar; is that fair?
A No. I think --
MR. McALPINE: Objection. Mischaracterizes the witness's testimony.
A I think that a lot -- I think that -- I have done life care plans. I just want to be clear. I want -- I have done life care plans for individuals with spinal cord injury with ankylosing -- not with ankylosing spondylitis but with spinal cord injury and with similar, you know, ending disability, so if that answers your question.
Q (BY MR. GREENE) Okay. So you have never done a life care plan for an individual who had ankylosing spondylitis; is that fair?
A No. I have treated patients with ankylosing spondylitis, but, no, I don't believe I have done a life care plan for that. Usually it's more -- people with more traumatic injuries that end up getting life care plans.
Q Let me ask the question again so that we have a clear record.

And let me just say this: Unless I ask you about your clinical practice, I am only talking about your litigation practice, the life care plans that you have written today. Okay?
A Uh-huh.
Q I will clarify for you if I am talking about your clinical practice. All right?
So have you ever written a life care plan for an individual with ankylosing spondylitis prior to Mr. Aguilar?
A Sorry. So are we just talking -- you are just going to say Mr. Aguilar only has ankylosing spondylitis or --
Q No.
A Okay. So, no. So, no, I have not written a life care plan for an individual with ankylosing spondylitis only.
Q Have you written a life care plan for an individual who had ankylosing -- ankylosing spondylitis and paralysis of the lower extremities?
A No. Mr. Aguilar is the first one who has had both of those things.
Q Okay. I think you testified earlier there is no way for you to really go through each one of these individuals identified on Exhibit No. 8 to tell me what

each case involved, right?
A No. I mean, I can kind of remember, but I don't recall.
Q So the next thing you produced in response to the subpoena, we will mark it as Exhibit No. 9, and these are three invoices.
(EXHIBIT 9 WAS MARKED.)
Q (BY MR. GREENE) Prior to today, are those the only three invoices that you have submitted in this case?
A No. There are a few more. They are all on the USB. Basically for additional record review and then my prep time for today.
Q Tell you what, this is what we are going to do: We are going to take us a break.
A Yeah.
MR. GREENE: Can you go and print whatever these invoices are that are on the USB, because I don't have them?
MR. McALPINE: Let me see if our printer is functioning properly.
MR. GREENE: In the whole office?
MR. McALPINE: To the extent I am able, I will be happy to do that.
THE VIDEOGRAPHER: We are going off the

record at 10:29 a.m.
(RECESS FROM 10:29 A.M. TO 10:42 A.M.)
THE VIDEOGRAPHER: Going back on the record at 10:42 a.m.
Q (BY MR. GREENE) Dr. Iversen, we took a short break. We were talking about the invoices that you produced in response to the subpoena, which were marked as Exhibit No. 9. And then you brought to my attention that there are several more invoices which were on your --
A USB.
Q -- USB drive. We will mark these as Exhibit No. 10.
(EXHIBIT 10 WAS MARKED.)
Q (BY MR. GREENE) And just so that I am clear, because I have no idea what's on your USB drive -- I figured we had all of the invoices, like I am assuming we have all of the other materials, but as we go through the deposition, I need you -- for example, when we get to your report, we will look at things you have reviewed and we will reference the document that you brought today, which is another list of information you have reviewed, which is marked as Exhibit No. 2. I need you to let me know what's on the USB drive that is not in any of these lists. Okay?

A Okay.
MR. McALPINE: Objection. Too general.
Q (BY MR. GREENE) To the extent that you can.
A All right.
Q Okay. So Exhibit No. 9, let me see that, please.
A (Witness tendering.)
Q These are the invoices to date -- excuse me -- the invoices that were produced back in January, 2017. How were these invoices created?
A Physician Life Care Planning creates the invoices.
Q I'm sorry. Say it again.
A Physician Life Care Planning creates the invoices and bills the law firm.
Q Is there one particular person who does that?
A I don't know.
Q Is that a case manager function?
A No. They have other people to do that.
Q In looking at the first invoice, I think it's dated October 21st, 2016, there is a rate of $9,250 for a catastrophic life care plan. Is that just a flat rate that you charge?
A That's a flat rate that Physician Life Care Planning charges for a catastrophic plan.

Q And then there is another charge, $500, for interview and examination and it says, "Physician Life Care Planner."
What does that mean?
A So that means the -- they had the date here that the IME was scheduled, which is the charge of $500. That initial IME that was -- ended up canceled, but this is what Physician Life Care Planning charges for both. I get about half of the catastrophic life care plan amount, 4,050, and then I get the full amount for the IME, 500.
Q So the charge or the rate, the amount, for the catastrophic life care plan is split 50/50 between you and Physician Life Care Planning?
A Approximately, yes.
Q And then you get the full amount for any interview and examination that you perform or conduct?
A Correct.
Q And according to this invoice, which is Invoice No. 8223, on 11/14/16, "canceled IME appointment on 11/16; moving ahead without an IME - see WiMs."
Did I read that correctly?
A Yes.
Q What does "WiMs" stand for?
A That's our online database for communication.

Q What does it stand for?
A Oh, I don't know exactly the terminology. "Management systems" or something. I am not sure.
Q So when it says, "see the management system," do you know what that means?
A Yeah. It's like log in and see the -- they also make notes, so they let me know. There is nothing I have to do in WiMs, but that's what they -- they make a note -- like they will put this note in there so that everybody involved in the case can see that.
Q Okay. So --
A But there is nothing else in WiMs that is not here, so it's like -- they had the IME scheduled, but they canceled it two days prior so...
Q And what does that mean, "moving ahead without an IME"?
A Still doing the life -- they still want the life care plan.
Q Who is "they"?
A The law firm.
Q Is that normal?
A It happens on occasion.
Q Is it preferable?
A No, but sometimes if I can't see the individual or if, like, for the defense one, the defense

life care plan I prepared, I wasn't able to see him.
Q Right, but --
A Yeah, it's preferable.
Q So it's preferable that you perform your interview and examination?
A Right, but it's not -- I can do a life care plan without an interview and exam.
Q Right. And in that defense case, I assume you had a plaintiff's life care plan that you were rebutting, correct?
A That one, I actually didn't.
Q Okay. So you were able to do a life care plan without seeing the plaintiff. What did you rely on in that one?
A The defendant or...
Q Yeah, in the defendant one, I'm sorry.
A The records.
Q What records?
A In the defense life care plan?
Q Yes, ma'am.
A Whatever records they provided me.
Q Did they bring you with medical records?
A Yes.
Q Did they provide you with deposition testimony?

A I don't recall exactly what they provided me with.
Q Did they provide you with witness statements?
A I don't recall specifics of that case right now.
Q Did they provide you with anything that related to the --
A We are talking about this other defense case that I did, right?
Q Yes, ma'am.
A Okay.
Q Did they provide you anything related to -- other than information or medical records, did they provide you any information related to how plaintiff thought he was doing in terms of his recovery, his rehab, anything like that?
A I don't recall right now. Usually they kind of fill out a form. I don't remember if he did that for that case. Obviously, I like to get -- I will request -- I will request any time that I don't get to see them, at least -- like, I have done it based on a phone conference. I will try to get as much information as possible.
Q Yeah. And that's what's preferred, right?
A Right, yeah.

Q Because you want to be able to talk to the plaintiff and at least speak to him about what his concerns are, what -- how he is dealing with the problems that he is faced, as a result of the injury, correct?
A Right. And if -- in those cases where I haven't got to see the individual before the plan is kind of due, I always request to see them before deposition. So that's happened, you know, I don't know what percentage of the time, but that does happen. Not infrequently but...
Q Now, you told me earlier that essentially -- and correct me if I mischaracterize this -- but the case manager intakes the case based on contact from a plaintiff's law firm typically, right?
A There is -- from me, yes.
Q If it's a plaintiff's case.
A From me, yes, yes.
Q And why do you say, "for you"?
A There is a lot of -- there is actually physicians at PLCP, at Physician Life Care Planning, who do mostly defense, so it's like a mix. So for me I, right now, do more plaintiff, but I, you know, have done some --
Q And I tell you what, let's not distinguish

between plaintiff or defendant. Case manager intakes the call, and they decide which physician they are going to refer the case to?
A Right.
Q Is that what happened in this case?
A Right.
Q All right. So how do you find out about the referral?
A They will send me a message through WiMs.
Q So there is an e-mail?
A Right.
Q And does that e-mail reference the attorney?
A Yes. The attorney, the due date, the nature of the patient's -- or plaintiff information, nature of the injuries.
Q In your response to the subpoena duces tecum, you didn't provide any WiMs e-mail or WiMs notes or anything like that?
A No. I mean, it's like a proprietary software, so I don't have the ability to provide that. It's not mine.
Q Well, you understand you were supposed to provide any communications related to Gustavo Aguilar's case, though? Do you understand that, as part of the subpoena?

A I mean, we can -- I am not able to provide that to you. You would have to go to Physician Life Care Planning to do that. I --
Q Right. My -- well, let's go back to the beginning. And your testimony, if I believe -- I think what you testified to is when you received a subpoena, you sent it on to Physician Life Care Planning, correct?
A Right.
Q So Physician Life Care Planning had the subpoena, they had Exhibit A, they knew what they were supposed to provide, right?
A Right.
MR. McALPINE: Argumentative objection.
Q (BY MR. GREENE) So when you say I have to go to Physician Life Care Planning, they already had this information from you, true?
A I had to go to them for what?
Q No. You said I would have to go to Physician Life Care Planning to get the WiMs notes.
A But I am saying I cannot give you what's in WiMs. WiMs is not mine. WiMs is Physician Life Care Planning's. So for me to go and, like, print stuff off of there, I guess? I don't normally do that. It's basically just their proprietary software, which I work in, which is not my information.

Q So if I understand what you are saying, anywhere -- anybody who works anywhere, you have an e-mail address that goes to the company, right?
A No. It's actually just I have a login for WiMs, and I have like an inbox in WiMs.
Q Okay.
A So...
Q And you can't print anything out of that inbox?
A I don't know. Yeah, I mean, I...
Q You have never tried?
A No.
Q Okay. So in response to the subpoena, you didn't even try to print any communications regarding Mr. Aguilar?
MR. McALPINE: Objection. Argumentative, mischaracterizes witness's testimony.
A I did not try to print those, no.
Q (BY MR. GREENE) Okay.
A This is -- it's not my information to give, so you would have to contact Physician Life Care Planning to get that information.
Q Okay. And, again, I am not trying to argue with you, but it's my understanding that you didn't gather any of this information, did you? And when I

say, "this information," I'm referring to the information responsive to the subpoena.
A I don't have any -- you know, I cannot provide you with any other information other than what I have provided you.
Q That's not my question.
In response to the subpoena, you testified earlier that you didn't gather any of this information. You forwarded the subpoena on to Physician Life Care Planning.
Do you recall that testimony?
A Yes.
Q All right. So in response to the subpoena, you didn't gather any of the information, did you?
A I did not gather information from WiMs, no, because it's already in WiMs under Mr. Aguilar's case.
Q Okay. So you have made a distinction now. Did you gather information that you had in response to the subpoena?
A Yes. Yesterday I gathered everything, yeah.
Q Okay. We are kind of confusing things. Let's be clear.
The subpoena was responded to in January, 2017. In January, 2017, prior to producing these documents that are contained in Exhibit No. 5, what did

you do to respond to that subpoena?
A I complied with any questions that were asked of me as far as, you know, my file or -- I don't recall specifically if they asked me for my file or for anything that they didn't have, but they will respond and they have access to everything that I have access to, unless it's my handwritten notes, which on occasion they will ask me for my handwritten notes and I will send that to them and then they send it on. So I don't know specifically, you know, how that was responded to.
Q Who is the "they" and the "them" that you are referring to?
A Usually the case manager will respond to the subpoena and --
Q At Physician --
A -- pull the documents. Yes.
Q At Physician Life Care Planning?
A Yes.
Q So my question: The person who responded to this subpoena would have been a case manager at Physician Life Care Planning?
A I believe so, so.
Q Did you respond to this subpoena in January, 2017, by doing any work to produce any documents?
A I -- everything is -- you know, I am actually

delegating that task to Physician Life Care Planning in that case. So anything that they didn't have, I will make sure they have and then they will go ahead and send it on, so that's kind of like...
Q I tell you what, tell me what you did to respond to the subpoena, because we are kind of not getting to the point here. Tell me everything you did to respond to the subpoena in January, 2017.
MR. McALPINE: Objection. Asked and answered.
A I provided anything that was requested of me by Physician Life Care Planning, and they responded on my behalf.
Q (BY MR. GREENE) What did you provide to Physician Life Care Planning?
A I don't recall specifically, at this point in time, if they did request my handwritten notes. I don't think they did at that point, because I hadn't seen him. So I know they have access to my life care plan and they have access to all that stuff, so I don't -- I didn't provide them with anything in addition to that.
Q You have your handwritten notes with you today?
A Yes, I do.
Q Can I see those?

A Yes (tendering).
Q Thank you. What does "DOS" mean?
A "Date of service."
Q Date of service. All right.
So if the subpoena was responded to in January -- on or about January 10, 2017, your date of service for these notes was January 26, 2017, you didn't have these notes to include them in the subpoena, did you?
A So I wouldn't have been asked. That's why I said I didn't -- I don't remember if that was included or not.
Q So other than Physician Life Care Planning asking you for your handwritten notes, would there be any other documents that you may have that Physician Life Care Planning wouldn't have in response to the subpoena?
A No.
Q All right. And sitting here today, do you recall assembling any documents to provide to Physician Life Care Planning in response to the subpoena in January, 2017?
A Why would I do that, because they already have everything that they need to respond, so I don't understand.

Q (BY MR. GREENE) The answer to my question is "yes" or "no."
MR. McALPINE: Objection. Argumentative.
A I don't know what you are asking. Like, basically so --
Q (BY MR. GREENE) Did you --
A -- they have everything that they need to respond on my behalf, so that's what happened.
Q Well, that's what I am trying to get to, but you -- let's try it again.
Physician Life Care Planning, those are the folks who responded to the subpoena, correct?
A On my behalf, yes.
Q What work did you do to assemble documents to give to Physician Life Care Planning to respond to the subpoena?
A I did what was asked of me as far as completing the life care plan so that, you know, they have the final copy of it and then, you know, billing out any time so that they have a copy of those things.
They may have asked me for an updated testimony list, which that is another thing I typically provide for them. I don't know specifically if they did in this case. I don't know if there is anything else.
Q Okay. And there is no way to confirm through

a written communication what they asked you for; is that fair?
A Correct.
Q Would Physician Life Care Planning have access to written communications between their case manager and you regarding Mr. Aguilar's case?
A Possibly. I don't know if they keep -- keep, you know, track of that.
Q And when you log on to WiMs, is there a drop box or a category or subfolder for the Aguilar case?
A Right. There is, like, a tab for him.
Q And that tab, what does that tab contain, in addition to medical records?
A Everything about the case, so everything that I need to know about the case.
Q So the communications regarding the case would be under that tab?
A The initial communications in my inbox and then if there -- they will kind of put notes on one of the subtabs.
Q And who would have taken notes about the initial contact, the initial phone call, from the plaintiff's attorney?
A The case manager.
Q Do you know where those notes are stored?

A In WiMs.
Q So they are stored somewhere?
A If they made notes, I said it was in the subtab under Mr. Aguilar in WiMs, yeah.
Q Sitting here today, have you ever -- do you recall, rather, reviewing any notes regarding the initial contact related to the Aguilar case?
A No.
Q Well, how did you know what to do?
A I mean, I didn't -- like, I got the initial, you know, message from them in my inbox, but then I -- then they -- you know, we do the scheduling. We -- I mean, I -- this is what happens with every case, so I am not sure...
Q Well, it sounds to me like there are e-mails that go back and forth about Mr. Aguilar's case, right?
A There are messages in WiMs, and then they make case notes and then, you know, phone calls. And if there is anything that comes up, like I -- I don't have full memory of everything that was discussed.
Q There are communications in WiMs about Mr. Aguilar, right, and his case?
A There would be about any case, yes.
Q Well, specifically the Aguilar case. That's the only one we are talking about right now.

A I would assume so. I don't know what those are exactly. There will be routine things that, you know, cancel the appointment, can't make the appointment, talk to, you know, whoever about rescheduling, like, things like that.
Q How many hours does it take you to draft the catastrophic life care plan?
A It's really dependent on how many records there are so -- there are typically more records with a cast, so I would say -- I don't keep track of my hours when I do the initial plan. I mean, I have to afterwards, but I would say maybe five, six hours.
Q When you receive the communication in WiMs from the case manager, do you recall whether it requested you to do anything other than prepare a cast life care plan?
A I don't recall anything else.
Q Did it provide you with any details about Mr. Aguilar's condition?
A It will -- I don't recall specifically for him. It usually will just say, you know, "fall, paralyzed from the waist down." Like, it will give me a couple of lines about him. It's whatever the attorneys will kind of put in that box so -- or tell the case manager, so I don't recall specifically what was in

this.
Q All right. You think it -- you estimated it took about five to six hours to draft the life care plan in this case?
A Right. And then, you know, maybe additional for reviewing some of the records. And I can't really give a number, but it's -- it is, you know, a significant amount of hours to do a catastrophic.
Q Based on the records that you reviewed for your December 1st, 2016, report, about how many hours did you expend reviewing the records? And you can look in the records there. I don't know if you have them memorized.
A I can't -- I really don't -- I can't say how many hours it was, because I look at the raw records, I looked -- I go back and forth. It's really hard to say, you know, how many hours total.
Q In Exhibit No. 9, the next invoice that you produced was an Invoice No. 8900. It says, "Retainer for travel for out-of-town IME - remainder to be billed after IME completed," $1,000. IME, January 26, 2017.
A Right.
Q And is that reflected in the physician consultation? Is that the IME?
A Right.

Q Which is marked as Exhibit No. 3.
Now, why is that out-of-town travel?
A They are in San Antonio, so they think -- you know, Pasadena is actually different than Houston, so that's out of town.
Q The next invoice in Exhibit No. 9, Exhibit [sic] 9019, it's dated 1/16/2017. It says, "medical records" is the activity. Quantity, 103. Rate, $1.
A Can I see that?
Q (Tendering to Witness.)
Explain to me what that is.
A I think this might be an error of what the actual activity is. I am not -- I'm not sure. I will have to get back to you, because normally it's not billed separately, but they may have started to, since the plan had already been completed. I will have to get back to you on that. I am not sure.
Q What does the quantify refer to? Number of pages?
A Pages probably, yeah.
Q And we have no idea what medical records -- what 103 pages of medical records were reviewed, based on this invoice, do we?
MR. McALPINE: Objection.
A I am not sure, because there were like

about -- there were thousands of records uploaded after this report was done, so I will have to get back to you if that's an error or not.
Q (BY MR. GREENE) So sitting here today, you have -- you really have no explanation because you are confused by the entry?
A It might be -- it might be -- yeah, I don't know. I...
Q It might be what?
A I was thinking mileage, but that doesn't make sense so -- because it was -- the IME had not been done yet, so I apologize for that. I will get back to you on that.
Q No, no worries.
Going to Exhibit No. 10, which are the invoices that you produced today -- well, actually, let's go back to Exhibit No. 9.
So based on my math, the total for Exhibit No. 9, you billed $10,853 on this case up through January 16, 2017. That's what's reflected in the invoices?
A Right.
Q And that's what you billed, as far as you know?
A Up until that date, yes.

Q Now, why did your -- let me ask it a different way.
What is the difference between an IME and the interview and examination?
A It's the same thing.
Q Well, why is one billed at $500 and one -- the other billed at a thousand dollars?
A Basically, since it was -- involved traveling, it's including the time. I think there was -- because he had missed it and then it was kind of not really out of town, so I remember having a phone conversation saying, "Are you willing to go down on the price?" Because it's a lot more than a thousand dollars for out of town, normally, and I would normally bill more for travel time and things like that.
So I think that was the agreement that we came to, based on, "Okay, we have already" -- "they already paid that initial IME" and then -- I don't recall specifically. I remember maybe a phone conversation about, "Okay, he had to cancel. He had this accident. Can you just see him at the facility?"
And I agreed to, and so I gave them the price. It's basically a discounted rate for that follow-up visit, since the initial was canceled so...
Q He is really not that nice to give him a

discount, trust me. I am just joking.
A Well, it's all back to the individual, so it's...
Q Well, Mr. Aguilar is a nice guy.
The next set of invoices you gave me are the ones marked Exhibit 10, and what I am going to do is compare and contrast. So we have exhibit -- or, excuse me -- Invoice No. 8223. That's in both 9 and 10. We have Invoice 8900 that's in 9 and 10, and that's the charge for the IME on 1/26/2017?
A Uh-huh.
Q And the next invoice that I have in Exhibit No. 10 is Invoice No. 9124, and this is for "Travel expenses - IME mileage - 90 miles." Quantity, 1; rate, $50.40.
Is this the invoice you were referring to, with respect to travel to see him --
A Right. That's --
Q -- at the facility?
A Yeah, that's...
Q And then Exhibit No. 10 also contains an additional invoice, which is -- the activity is identified as "Sworn testimony - life care planner (in office) 1/2 da7, deposition 4/4/17." The rate is $3,000?

A Right.
Q Okay. So a half-day deposition is how many hours? Four?
A Four hours.
Q So you charge 750 an hour?
A Basically, I -- the total is 3,000. That is paid to Physician Life Care Planning. I get 2,000 of that, so it's basically 500 an hour.
Q So you and Physician Life Care Planning, combined, charge 750 an hour for deposition testimony?
A Yeah.
Q For the services rendered?
A Yes, yes.
Q All right. As I understand your testimony, you will receive $2,000 of that, based on the assumption that the deposition will last four hours, thus, $500 an hour?
A Right.
Q Are there any other invoices where your time can be, I guess, accounted for in terms of hours and the specific rate per hour?
A Right. So I just put in some additional hours last night, as far as plugging them in for expenses or prep time. So I did three hours of prep time and two hours of record review, like, within the past few weeks

so...
Q Okay.
A So an additional five hours basically.
Q All right. So there is a flat fee for the catastrophic life care plan of $9,250, right?
A Right.
Q And based on this, for this particular case, there was a $1,500 charge for the interview and examination/IME?
A Right.
Q And then you charge about $500 per hour for appearing at the deposition and preparing for it?
A Yes, that would be right.
Q And with the prep time, does Physician Life Care Planning also receive money for your prep time?
A Right. They get 100 of the 500, so I will get 400 of the 500.
Q Okay. Let me back up because I am confused and let me -- I may have confused myself actually.
A Yeah.
MR. McALPINE: I think so.
Q (BY MR. GREENE) So with the deposition is $3,000, four hours, that's 750 an hour, right?
A Right. So that does not --
Q 250 --

A -- include prep time.
Q Right.
A Okay.
Q Understood.
250 of that per hour is for Physician Life Care Planning and 500 of that is for you?
A Right.
Q And that's your deposition rate?
A Right.
Q All right. Now, your preparation rate is what?
A It's 400 an hour.
Q 400 an hour.
All right. And then Physician Life Care Planning charges an extra 100 on top of that?
A You got it, yes.
Q So three hours of prep time, there should be another invoice coming for about $1,500?
A Right.
Q Of course, I have lost my notes with the totals.
I think I said earlier 10,853. That was including the one invoice that we can't recall explain. Another $3,000 today. That's 13,853.
A Uh-huh.

Q And then another 1,500 for your prep time. 15,353? Sound about right?
A Approximately, yeah.
Q And is that all the time you anticipate billing in this matter, prior to going to trial?
A Yes, unless I am asked to do a supplemental report, in which case -- usually it's about -- you know, I have already reviewed a lot of the things, so I would say, like, about two to three hours, if they do ask me for a supplemental.
Q And a supplemental report, is that billed on an hourly basis or a flat fee?
A It's hourly.
Q What is the hourly rate for a supplemental report?
A 500 an hour.
Q 500 for you or 500 total?
A Total.
Q How did you get this job at Physician Life Care Planning?
A They actually found me on LinkedIn. They needed a physician in Houston for life care plans, and I was, you know, in Houston since 2012. I had started my own practice, was looking to kind of do, you know, a few other things as well, so I responded to their -- their

request and message.
Q And after they found you on LinkedIn, was there an interview process?
A Yes.
Q Do you recall who you interviewed with?
A Several people. The owners and the -- first of all, it was like the -- I don't know what you would call it, like the headhunter person and then the owners and then the people with the staff.
Q So there was a headhunter involved?
A Not a headhunter, but it's their person at the company who was responsible for finding -- he is not there anymore, but he was hiring new people basically.
Q Okay. And was there any training involved for you?
A I did have, like, my initial life care plans reviewed by the founder of the company who is a PM&R life care planner, who has been doing it for about 30 years, and then I did a certification on my own with -- through the ICHCC, which is the International Commission on Health Care Certification, for the certification in life care planning. I kind of did that training ongoing as I was doing the life care plans.
Q I'm sorry. What is that training again?
A Certification life care -- it's a CLCP

credential, so certification in life care planning -- certified life care planner.
Q And you said that's an ongoing certification?
A No. Like in the begin- -- I am certified now, but in the beginning, I -- you know, it takes some time, obviously, to do all the coursework so...
Q And I would imagine, as with most professions, do you have to do continuing education?
A Yes, yes, I do.
Q And are you up to date on your continuing education?
A Yes, sir.
Q What is the last continuing education class you took?
A I don't know actually the last one. I mean, I'm -- they have various ones, so it's maybe through IARP, the International Association of Rehab Professionals. I mean, I am a member of their -- the forum, and I get all the literature and everything, so I am constantly reading. So I can't really say the last -- I have an upcoming conference this week for the CLCP credential, actually.
Q Now, you said initially the founder of the company would review your life care plans. Is that Dr. Joe Gonzales?

A Yes.
Q And you spoke earlier about proprietary information, WiMs being one. I imagine there is more proprietary information that Physician Life Care -- Physician Life Care Planning has?
A I am not sure about all their things.
Q Okay. And there was no training that you underwent on how to write a life care plan?
A I mean, they did go through, like, what -- the basic things that I also went over in the independent certification as well. I don't recall specifically all the training. It wasn't -- it wasn't like a sit-down classroom or anything like that. It was -- I mean, the thing about life care planning is there is a really big overlap with PM&R.
If you look at -- you know, obviously, I read the textbook and I did all the online coursework and all that, but there is a case management handbook for life care planning. And in that, basically, is the statement of the importance of a PM&R physician, specifically in the life care plan, because you need the medical foundation for the actual life care plan, because you need -- you know, either the life care planner has to get a PM&R physician to do it or the PM&R physician, you know, themselves does it so...

Q My question to you was: At Physician Life Care Planning, was there training that they provided to you --
A Not --
Q -- when you first started?
A Not specific training. It was more --
Q What was it?
A It was more just the peer review that was back and forth with Dr. Gonzales.
Q And Dr. Gonzales, I imagine, told you what his expectations were for his life care planners? Yes?
A Actually, it was more that -- it was very much imprinted on me that it's my opinion. So, you know, a life care plan is going to be very different between different experts, obviously, so he said, "Use your experience to" -- "you know, if" -- "what you think they need."
I mean, obviously, like some of the process work, there was some guidance work as far as, okay, you know, doing the vendor survey and the process and the methodology that is expected, because that is expected of any life care planner. But as far as the content, it was left up to me. As far as the process, I mean, there was some, you know, kind of, "Here is what we do. We schedule" -- "we" -- "you have all the records, you

schedule the person, you start formulating your opinions and then come to conclusions. And then we will have, you know, a vendor team assist you with doing the research so that we have a plan at the end of it."

And that's the basic methodology, by the way, so -- but as far as the content, that was up to me. As far as the process --

Q No, no, I apologize. I am not -- if my -- perhaps my statement was misworded, my question, rather.

I am not saying that anyone told you what to put into your reports. But, as you said, the process and the methodology, they did --

A Right.

Q -- help you out with that --

A Right.

Q -- to give you a framework --

A Yeah. I mean, I recall --

Q -- and guidance?

A Right. I recall -- there is an article in the PM&R Journal that is kind of a nice outline of PM&R and the involvement with the life care planning specialty and how nicely tied it is and the methodology. And so that's from 2014, I believe. So that was sent to me, I remember.

Q I'm sorry. What was sent to you?

A A journal article, peer-reviewed journal article, from my -- PM&R. It's called -- that's the name of the journal. It's the purple journal from the PM&R specialty.

From 2014, there is an article in there that discusses the discipline of life care planning and how it's involved with PM&R.

Q Who wrote that article?

A There were several people. Mol... I forget the name of the...

Q Is it an article that Physician Life Care Planning had any input into?

A I think -- I believe that they did. I mean, it was obviously peer-reviewed, but I think that there were -- I don't think it was Physician Life Care Planning. I think it was some of the individuals at -- who were employed by them.

Q Is clerical time, all of that is subsumed in the invoices already, correct?

A Right, yes. So that's kind of their -- the Physician Life Care Planning, their amount that they take is kind of the clerical.

Q Other than Rebecca Pese, is there anyone else in the office that you worked with on this case?

A Yes. So I will have kind of an assistant for

each specific portion. So I will have a case manager for each case, I will have a vendor specialist to assist me with the search, and then I will have a person assisting me with the record review, to kind of put everything in chronological order and actually, you know, type it out, so to speak, so they are looking at the record and typing it. I am reviewing it all but -- so I have a vendor person, and I have a record person and...

Q And the vendor person is the one who does the research on the vendor costs, charges, fees, that sort of thing?

A Correct.

Q Okay. And the records person does what exactly?

A They will have the raw records, and they will be responsible for kind of transcribing them over into the format that you see --

Q In the report?

A -- in the report, as far as the records go, and then I review everything and make sure that that's what I want in the report. They are not changing any of the wording, so it's not content-wise. It's just they are taking the records and kind of transcribing them into a typed format so that it's easily readable.

And then the other big thing that they help me with is putting everything in chronological order, because we get these thousand of records, and for time purposes, it's helpful for me to have an assistant to do that.

Q And the invoices in Exhibit No. 10, those are the most current, up-to-date invoices, right?

A Except for the ones that we talked about, yes.

Q I'm sorry.

A Yeah.

Q That's correct. The preparation time, I'm sorry.

And there may be another invoice, for example, if we go beyond half a day today?

A Right.

Q And if he asks you for a supplemental report?

A Right.

Q But right now, everything is current, other than the preparation time?

A Yes, sir.

Q Do you know or do you have any idea when a decision will be made regarding whether you are going to do a supplemental report?

A No.

Q Do you want to do a supplemental report? That

was a bad question.
A There will be some questions, so I am -- you know, I can kind of tell you that and then you can -- it's up to him, really. It's not up to me so...
Q Let me ask it a different way.
MR. McALPINE: That's a good question.
Q (BY MR. GREENE) Is it necessary to do a supplemental report?
MR. McALPINE: Objection. Well, yeah, objection. Calls for speculation.
A I do have some changes so -- it's not really up to me as far as if he is going to request one. I mean, I -- they will be in -- there will be some changes, and that will change the final number. And for that to get all calculated out, then we will need to do a supplemental report, but, again, I am not the one deciding that.
Q (BY MR. GREENE) Right. It sounds like, if it were up to you, there would be a supplemental report that would reduce the numbers at some point?
A If he needs a specific number, then he will need a supplemental. It doesn't really matter what I want. Just he will need -- if he wants specific numbers, based on my change of opinions, then he will need to request that.

Q Now, the next thing you produced, in response to the subpoena, was your report, and we will mark this as Exhibit No. 11.
(EXHIBIT 11 WAS MARKED.)
Q (BY MR. GREENE) And this is a 76-page report. And we will get into the substance of the report, but based on your previous testimony, is this your final report?
MR. McALPINE: Objection. Confusing and misleading.
A As of today?
Q (BY MR. GREENE) Uh-huh.
A It is my final report, as of -- you know, we kind of talked about that.
Q Yeah. Based on what you have told me, though, this report that I have just marked as Exhibit No. 11, it does not contain all of your opinions?
A No, and it doesn't contain my physician consultation. It doesn't contain the subsequent records that I was provided. You have those in the other exhibits, but -- and it doesn't contain any new opinions that I have formed since December.
Q When did you first tell Mr. McAlpine about your new opinions?
MR. McALPINE: Objection. Asked and

answered.
A About what?
Q (BY MR. GREENE) Your new opinions.
MR. McALPINE: Objection. Asked and answered.
A Yesterday.
Q (BY MR. GREENE) Yesterday?
A Yeah.
Q But this -- so far, this is the only report you have done in this case?
A Correct.
Q Are there any drafts?
A No.
Q Do you work in drafts?
A I -- yeah. So in WiMs, I can kind of make changes to -- it's like a live-time thing, so I just hit "save" and it will kind of update to the newest version so...
Q It just saves over whatever version you were working in before?
A Yeah.
Q And you don't save a Version 1, Version 2, Version 3 to go back --
A I don't have anything saved, yeah.
Q Did anybody assist you with drafting this,

other than the case manager?
A The case manager doesn't assist me.
Q Who assists you with this? I think you told me the vendor?
A The vendor specialist and then the record specialist, but that's kind of -- they are kind of done with their part, unless I have questions or changes or "go look at this record, make sure this is correct" type of commentary.
Q Okay. And with respect to -- I mean, this is 76 pages. Did you draft this from scratch?
A I drafted the majority of it, obviously with assistance. Some of it is introductory, so some of it will be the same in other life care plans that I've done, for example, at the beginning.
Obviously, the table of contents is generally the same but specific to Mr. Aguilar, and then "overview" is pretty much the same throughout any life care plan, except for where Mr. Aguilar's information is.
And then on to Page 3, it's specific to Mr. Aguilar, and I go through and make sure that that's kind of the wording that I want. And then if there is any decrease in life expectancy or things like that, that that will be all specific to him.

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And then with my assistant for the record review, you know, they are helping me, but I am the one who is kind of having the final say of the report. So, in essence, it is my report. Do I sit there and type every word of it? No, I don't, but I subscribe to and I, you know, am adopting it as my own, basically.

There is also some -- in the catastrophic plans, there are some explanatory language in Section 3, so -- or, sorry, in Section -- yeah, in Section 3, just to kind of explain to the reader, because that's kind of the whole discipline of life care planning is: What is a life care plan? Who needs it? What does this injury even mean?

So it's explanatory because the -- I actually tell the individual that I am doing it for, I said, "I can't give it to you unless you request it, because it's very good information for you," because, as a physician and as a life care planner, my job is to educate.

Q Okay.

A So, yeah.

Q But in terms of drafting this life care plan, there was you, right?

A Right.

Q There is a record review person, right?

A Uh-huh.

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Q And there is a vendor person, correct?

A Correct.

Q All right. What's the vendor person's name?

A I don't -- I don't recall for this. I believe it was Kristin, but I don't...

Q Do you know Kristin's last name?

A No. I think it starts with an "A," but I don't think she's actually -- I think she changed jobs.

Q All right. Who is the --

A I don't remember.

Q -- medical records review person who assisted you with this report?

A I think it was Franco, but I don't...

Q You don't know Franco's last name?

A I don't know -- I don't -- no, I don't know if it was him for sure so... I can find that out for you.

Q Do you know Franco's last name?

A Starts with an "S."

Q Okay.

A But, again, I am not 100 percent if it was him or not. There is a -- you know, with different cases going on, I don't keep track of everybody.

Q Well, what we will do is we will leave a space in the deposition. When you read it, please put in the name of the vendor --

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A No problem.

Q -- personnel who assisted you and the name of the medical records reviewer who assisted you. Okay?

A Yeah.

(REPORTER'S NOTE: The Witness will please include this information on the errata sheet when she reads and signs the deposition.)

Q (BY MR. GREENE) As I understand it, the substantive work -- the only substantive work you have done since you wrote this report was you conducted your IME and you have reviewed other medical records?

A Right.

Q Okay. Anything else?

A No.

Q Now, at the time you authored your report, you did receive certain medical records, though, right?

A Right.

Q And if I recall, your report is based on medical records from October 11, 2013, through March 17, 2016?

A Right, right.

Q And at the time you wrote your report, based on those records and everything you had done up to December 1st, 2016, you felt like you had enough information to render the opinions that are contained in

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the report, which is marked as Exhibit No. 11, correct?

A Right.

Q I mean --

A Right.

Q -- if you didn't think you had enough information, you would not have written the report --

A Correct.

Q -- is that correct?

A Correct.

Q All right. And throughout the report, you provide sources of different factual information, right?

A Yes.

Q And that's part of the methodology, right?

A Right.

Q The facts that are in here, did you identify all of the documents that are the sources or bases for those facts?

MR. McALPINE: Objection. Too general.

A Yes. I believe I did, yeah. They are listed in section -- on Page 5, Section 2.11 -- 2.1.1.

Q (BY MR. GREENE) And is it true that all of your opinions regarding Mr. Aguilar's life care plan, as of December 1st, 2016, are contained in this report?

A All my opinions?

Q As of December 1st --

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A Yes.
Q -- 2016.
A Yes.
Q And those opinions were based on the medical records from the date of the incident until March of 2016, right?
A Right. I also did get a -- like an intake form, because I wasn't able to see Mr. Aguilar, so they had -- they sent me an intake form.
Q Who is "they"?
A Mr. McAlpine sent me an intake form, like, kind of about his current status basically. It's what -- what they would fill out before -- before a visit with me. I just didn't get to see him yet.
Q Is it your testimony that that intake form also formed the basis --
A Yes.
Q -- of your opinions --
A Yes.
Q -- here?
A Yes.
Q Have you had the opportunity to review Dr. Garrison and Ms. Stegent's reports in this case?
A Yes, I have.
Q Let me go back a little, hold on, with your

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CV.
When you were a chief resident --
A Yes.
Q -- what were your job duties back then?
A I was in charge of scheduling the residents and any research meetings and, like, journal club, things like that.
Q As a chief resident, you didn't write any life care plans, did you?
A No.
Q Would the first life care plan you ever wrote have been sometime after joining Physician Life Care Planning in 2014?
A Yes, sir.
Q Do you recall the first one?
A No. I don't remember the name, sorry.
Q Oh, you have got to remember the first one.
Do you remember the -- approximately when in 2014 it was written?
A Like, November, 2014.
Q And did you start there in the beginning of 2014?
A No. I started October, I think.
Q So you started in October, and you wrote your first life care plan. Let me back up. I'm sorry.

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So you started in October of 2014, and you wrote your first life care plan in November of 2014, correct?
A Yes.
Q And is that the one that Dr. Gonzales reviewed with you to kind of get you going and make sure everything was, for lack of a better phrase, up to snuff with respect --
A Yes.
Q -- to how --
A Yes.
Q -- Physician Life Care Planning, they write their life care plans?
A Yes.
Q All right.
A And that was ongoing until early 2015.
Q Okay.
A March maybe. And he was always available if I had questions or anything.
Q All right. And one of the things that you learned early on in writing life care plans was that life care plans should be individualized, right?
A Right.
Q And that's one of the reasons why you have to look at the medical records, true?

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A Right.
Q And you have to do your examination so you can find out what the injured person is actually complaining of and what his injuries actually are, true?
A Right.
Q We spoke earlier about, well, the guidelines for a life care plan. Would you agree with me that the foundation of a life care plan should be credibility and transparency, yes?
A It's important, yes. I don't know -- I think the foundation is the individual and their impairments so... What the --
Q Well, in terms of --
A -- individual has, yes.
Q In terms of the person actually authoring the life care plan --
A Okay.
Q -- that person's credibility and that person's ability to be transparent, those are the foundations of the life care plan?
MR. McALPINE: Objection.
Q (BY MR. GREENE) The actual document.
MR. McALPINE: Compound and vague.
Objection. Compound and vague.
A I think I just kind of disagree with you on

semantics, but I think it's important, yes. I mean, it's...
Q (BY MR. GREENE) Well, and it's important because --
A Yeah. Obviously --
Q Well, let me finish --
A -- I have to have --
Q Well, let me finish my question.
A I have to have the...
Q It's important because, as a life care planner, credibility and transparency show that you are competent, one, right?
A Right.
Q Show that you are professional --
MR. McALPINE: Same objections.
Q (BY MR. GREENE) -- correct?
A That I'm...
Q That you are a professional.
A Yes, sir.
MR. McALPINE: Same objections.
Q (BY MR. GREENE) And it shows you are ethical?
MR. McALPINE: Same objections.
A Yes.
Q (BY MR. GREENE) All right. And in order to be considered transparent, some of the factors you look at

would be whether the life care plan contains a complete synopsis of the medical records. You want to have that, right?
A Correct.
Q You also want to have a complete account of the personal interview and physical examination, right?
A If it's available, yes.
Q Well, that's an important thing, though, right? You would agree with that?
A It's -- yes, it's important. Can I do a life care plan without it? Yes.
Q No, and I am not saying you can't do one without it, but you would agree with me that it is an important aspect of a life care plan?
A Yes.
Q All right. And you want specific identification of all diagnostic conclusions; is that true?
MR. McALPINE: Wait.
A Specific --
MR. McALPINE: Objection. Vague.
Q (BY MR. GREENE) Specific identification of all diagnostic conclusions.
A Right.
Q What are "diagnostic conclusions"?

A They are basically a list of things that the individual has, so what's wrong with him.
Q Basically his diagnosis?
A Right.
Q You also want specific identification of all consequent circumstances. Do you know what "consequent circumstances" are?
A You can explain it.
Q You don't know what it is?
A No. I mean, I --
Q You have never heard that phrase?
A Like how the accident happened or... Is that...
Q Well, the things that flow from the consequences of it. If you have never heard of the phrase, you have never heard of the phrase?
A I don't have -- I have not heard of it.
Q So when we talked earlier about -- and I think you mentioned this -- but kind of the methodology, you need your facts, you need your opinions, and you need your conclusions, right?
A Uh-huh.
Q Yes?
A Yes.
Q Now, what is the difference between the

"opinions" and "conclusions"?
A Basically the opinions are my opinions. It's what I think that the individual has and what he will need.
The conclusions are going into the costs, so I have to do my research before I come in to any monetary conclusions.
Q And the facts are the objective findings, true?
A Right.
Q The objective findings are based on, one, the medical review, medical record review?
A Right.
Q And, two, again, the personal interview and the examination?
A Right.
Q Those are the two things that form the bases for your factual findings and your -- your facts and your objective findings, true?
A Right. Well, part of the interview is also what the person is telling me, so, you know, that's the subjective part of the --
Q Right, but you still need that?
A Right. It's -- which I did have --
Q It's important?

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A -- the -- I did actually have the intake form, so I had his version of what he --
Q And why --
A -- reported.
Q So the intake form that you had when you wrote your report in December, on December 1st, 2016, that was another important piece of information?
A Right, which I mentioned before, yeah.
Q Okay.
A Because I said, "If" -- "Well, if I can't see him, can at least we get this thing filled out," because it was a little unclear because he had had another accident thing, so I wanted to know what was going on.
Q So if I understand it, you couldn't see him?
A Right.
Q And it's important to see him and conduct the interview and the examination, right?
A Right.
Q Since you couldn't see him, the next best thing, the next most important thing in terms of the subjective part of it, was the intake form?
A Right.
Q And the intake form...
A I believe it's on the USB.
Q Is that called the -- I think I have it -- the

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examinee information form?
A Yes.
Q That's what that's called?
A Yes.
Q All right. And because you didn't interview him, because you didn't examine him, that was an integral part of your opinions in the December 1st, 2016, report?
A It was part of everything. Everything is important, so it was part of it. I can't really say how important. I want as full of a picture as possible. So, you know, I ask for all the records, I ask for -- can I talk to him, can I see him, can I -- so that I can get as much information as possible.
And then when I do the report, I say if I am offered any other information, I have the, you know, right to amend my report, basically. So at this point in time, I had everything, and then I made the life care plan based on everything that I had.
Q Okay.
MR. GREENE: Do you want a break?
MR. McALPINE: What, am I squirming?
MR. GREENE: Yeah, a little bit.
MR. McALPINE: Yeah, yeah, yeah, please.
MR. GREENE: Okay.

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THE VIDEOGRAPHER: We are going off the record at 11:37 a.m.
(RECESS FROM 11:37 A.M. TO 11:46 A.M.)
THE VIDEOGRAPHER: We are back on the record at 11:46 a.m.
Q (BY MR. GREENE) Dr. Iversen, we were talking about the -- some general thoughts about life care plans before we took a break. I think we left off with the personal interview and the examination.
Would you agree with me that a life care plan that does not account for a personal interview, an IME, or your examination intake form is suboptimal?
A It's -- I would say it's not as complete as one that includes it.
Q And why would you say it's not as complete?
A Well, because now I've seen him, so I can make it more complete.
Q Okay. Well, let's talk about before you see him. Why wouldn't it be complete before you saw him?
A No, I think it was complete at this time with the information I had.
Q Yeah. No, no, not talking about yours. I'm talking about a life care plan that does not include personal interview, physical exam, or the examinee intake form. You would agree with me that that one is

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not complete, right?
A It's not ideal but, again, a life care plan, you know, what I always -- I think it's in there, too -- is that it's based on available information, so I reserve the right to amend it if I am presented with more information in the future. So I don't -- I didn't -- you know, I was, again, as you said, I am not going to do a life care plan if I don't have enough information.
I have refused to do life care plans in the past because they gave me, like, ten pages of records, and I can't do a life care plan on that. So I did, in my opinion, felt like I had enough information to complete a life care plan.
Q Right. And in this particular case, because we had to -- or you -- because someone had to cancel the examination and the interview, at a minimum, you wanted to have that examinee intake form to complete your life care plan?
A Right.
Q All right. And when we are talking about facts that are essentially the objective findings of a life care plan, objective findings, would you agree with me that those have to include a complete review of the subject's biological systems and symptoms?

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A If it's available. I mean, again --
MR. McALPINE: Objection. Vague.
A -- if you have that information, if you can get to talk to them and do a review of systems. I mean, it's part of the interview and exam portion of the life care plan so...
Q (BY MR. GREENE) I hear you saying, "if it's available," so...
A It's again -- I think -- it's part of the -- to me, it's part of the -- and it's part of the physician consultation because it's the history portion that the person is giving you. It's that first part, so I can do a life care plan without that subjective information.
If it's -- one thing that I do rely on sometimes is that if they have told other doctors recently what the symptoms are, then I also use that as well. So if they have told any doctor, that's subjective so...
Q All right. But more objectively, the life care plan should include an account of the health history, right?
A Right.
Q An account of the social history, right?
A Right.

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Q And an account of the medication history, true?
A Right.
Q All of those things build into your objective findings that support your facts; is that right?
A Right, any information I can get. I mean, if I can -- I have also gone to people's houses and got -- you know, gotten that as well. I mean, you can make it as detailed or as, you know, or as less detailed as you want.
So there is a large span of things. What I say is I want the most information that's readily available at the time I create that report. And if I get more information later, then we can amend it.
Q Okay. At the time you created this report, you had the necessary components of a life care plan, those being the diagnostic conclusion -- diagnostic conclusions. You had those when you wrote your --
A No. I actually formulate those myself.
Q I'm sorry?
A I formulate those myself as well.
Q Okay.
A So I collect any information, and then I formulate those are the things I'm -- my opinions are what he has, so I may see things in the records or after

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I examine the person that were not addressed. And I may put those in the diagnostic conclusions because I am a physician, and I have that inherent ability to put forth a diagnoses so...
Q Okay. Well --
A Just to clarify.
Q Okay. And along with the diagnostic conclusions, which you may arrive at yourself, right?
A Uh-huh, right.
Q You also want to know -- or, excuse me -- you want to identify any physical and mental circumstances that exist as a consequence of the injury or the condition or the disease?
A Right.
Q All right. And those are usually specified in the diagnostic conclusions, right?
A Right. So they will be, like, the impairments or the disabilities.
Q Right. And those, the -- those are the consequent circumstances, true?
A Right.
Q All right. So the consequent circumstances are impairment, disability, and life expectancy. Those are the three, true?
A Right.

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Q All right. And those are important in every life care plan, correct?
A Right. The main components -- how my wording is, you know, what the individual has, what they need, and what does it cost. Those are the three components.
So however you arrive at what they need, whether you are just using records or you are using records and their in- -- and an intake form with their information or you are using an interview and exam as well or -- you know, that's all part of coming to the conclusion of what they have, which is the diagnostic conclusions. And then from there, what impairments and what disabilities will they have.
Q I think your wording was "what they have, what they need, and what it costs"?
A Correct.
Q All right. And one of the things that affects what it costs is going to be the life expectancy, true?
A Correct.
Q And you would agree with me that you have to make adjustments to life expectancy, when necessary?
A Right.
Q And to do that, you have to consider all the risk factors that may result in a reduced life expectancy, right?

A Uh-huh, right.
Q So some of the bases for the adjustments would be -- I think in your report you relied on a third-party benchmark to establish the baseline life expectancy, right?
A Right, yeah.
Q And without looking at your report -- and we will get to it, but from what I recall, Mr. Aguilar was a 65-year-old man and you gave him a life expectancy of 19 years, true?
A Correct.
Q And a 19-year life expectancy is the normal life expectancy for a 65-year-old man?
A Right.
Q Healthy 65-year-old man?
A Population, so, I mean...
Q Healthy?
A This is not -- this is healthy and unhealthy. This is the general population.
Q Okay.
A This takes everybody into account: People with HIV, people with hypertension, people with obesity. It's the general population so...
Q Very good.
And when you have a person with HIV, you start

to reduce it, based on the fact that --
A Actually not so much now but -- that's another conversation but --
Q At one point --
A Yeah.
Q -- right?
A Used to be, yeah.
Q All right. And obesity?
A Right.
Q You would reduce life care --
A Possibly, yes.
Q You would adjust -- I'm sorry. Let me start over.
You would adjust the life expectancy for an obese person, right?
A Possibly, yes.
Q You consider the primary injury and its likely impact on life expectancy, don't you?
A Right.
Q And you consider the associated conditions and consequences and their likely impact on life expectancy, true?
A Right.
Q And you also consider any preexisting or newly developed conditions and their likely impact on life

expectancy?
A Correct.
Q And then you would isolate the specific individual and his unique risk factors as established by a doctor?
A Right.
Q And all of those factors are the way that you adjust the life expectancy?
A And then one more thing that you didn't mention that I take into account is I take into account my life care plan. So the whole purpose of this life care plan is to do four things: To prevent any complications, it's to get this individual to the highest level of function, highest quality of life, and then decrease any pain and suffering.
So part of the thought process in doing a life care plan is almost a -- it's kind of forward-thinking. It's being progressive and being -- trying to prevent those things before they happen, so it's not just doing the bare minimum.
So those things are actually -- you know, the things that I have outlined, making sure he has, you know, labs done, seeing the doctor on a regular basis, those are the things that are -- doing the suprapubic cath so he doesn't get wounds, whatever.

So those are the things that are going to help increase the life expectancy again, so -- just so that we are saying that, yes, there is definitely things that will decrease it, but, yes, there is definitely things that I am accounting for that are increasing it.
Q Well, I understand that, but there is no way to guarantee that you are going to increase somebody's life expectancy simply by writing something in a report, is there?
A No, that's true.
Q All right.
A But he will -- he can decide to follow it. If, you know --
Q Right.
A We don't know, yeah.
Q So, essentially, when you are saying you are accounting for certain things that may increase his life expectancy, you are assuming that that's going to happen, right?
A No. I am saying this is -- this is my recommendation for a plan of care, and this is the structure it would take. And if he does these things, more likely than not he will, you know, do better --
Q Exactly.
A -- than if he doesn't. If he gets minimal

care or no care with a spinal cord injury, you are going to have some pretty bad complications.
Q Right.
A Death, for example, so...
Q But, again, it's if he complies with it. You are assuming that he is going to comply with it, true?
A This is not kind of going back to that length to say what or what he is not going to do, because I cannot control that. What -- the life care plan is a model for care, and it is designed to take into account everything that he has and say that if he does these things -- and, by the way, these things are going to help him. If he does these things, this is what I believe is likely.
Q Okay. The adjustment for life expectancy, that's something that should be considered in the methodology for --
A That is, yes.
Q -- concluding or for coming to the opinions in the life care plan, right?
A Yes.
Q And when we talk about the methodology, it's -- I have seen it referred to as a "linear methodology." Would you agree with that or disagree with that?

MR. McALPINE: Objection. Vague.
A Yeah. Can you be a little more specific?
Q (BY MR. GREENE) Sure. Okay.
Linear, we are going across a line. Start with diagnostic conclusions, go to impairment, go to disability, you go to life expectancy adjustment, you end up at future medical requirements.
A So that's linear, yes. I mean --
Q Yes.
A -- I wouldn't say life expectancy in itself is, but it is a linear process.
Q Well, and not just life expectancy, but life expectancy adjustment in a life care plan is part of that methodology, true?
A True.
Q Let's look at your report.
Now, the methodology that we just discussed, is that the methodology you used to form the basis of your opinions in this case?
A Yes.
Q All right. And for each opinion that is expressed in Exhibit No. 11, you used that methodology, right?
A Yes.
MR. McALPINE: Objection. Vague with

respect to the methodology you just discussed.
Q (BY MR. GREENE) Do you understand what methodology I am referring to, ma'am?
A I mean, I can repeat it.
Q I don't need you to repeat it.
A Okay. Yes.
Q But do you understand it when I refer to it?
A Yes.
Q Okay. Now, if we look at your table of contents, this provides everything that's contained in your life care plan, true?
A Yes.
Q You have your "Overview," Section 1. "Summary of Records," those are all the records that you have reviewed at the time you wrote the life care plan?
A Yes.
Q The discussion regarding his injury and illness, future requirements, future medical cost, and then the vendor surveys?
A Yes.
Q If you would, turn to Page 2 of your life care plan, the last paragraph. "The physicians of Physician Life Care Planning also maintain an active role in diagnosing and treating patients with a wide variety of complex medical conditions and disabilities. They also

engage in long-term medical and rehabilitative care and disability management."
Did I read that correctly?
A Yes.
Q And when they --- when this, in your report, refers to the "physicians of Physician Life Care Planning," that includes you?
A Yes.
Q All right. Now, no physician at Physician Life Care Planning treated Mr. Aguilar, did they?
A Not that I know of.
Q Okay. And you did not treat Mr. Aguilar, did you?
A No.
Q All right. You don't have any plans to treat Mr. Aguilar; is that correct?
A No, not currently. I mean, I do treat patients who have had life care plans.
Q Right, but specifically with Mr. Aguilar --
A No.
Q -- do you plan on treating him at any time in the future?
A Not unless I am asked to do so.
Q Right. You were only retained to draft this life care plan?

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A True.
Q Since no one from Physician Life Care Planning or yourself is treating him, no one is involved in his diagnosis, right? The active diagnosis.
A Well, no, I guess. I mean, I can look at all the records and make my own diagnosis --
Q Right.
A -- but I am not treating him so...
Q Right. And you are not involved in his --
A I am not giving him any diagnoses.
Q Okay. And you are not involved in his long-term medical care?
A No.
Q Not involved in his rehabilitative care?
A No.
Q Not involved in his disability management?
A No, but this is actually to explain about the company and the background of the physicians, to explain that the physicians that are part of Physician Life Care Planning are kind of actively doing rehab. Maybe not on people that they are doing life care plans on, although that is true as well, but not, you know, the majority.
Q On Page 3, at the time that you wrote this report, have you had a conversation with Mr. Aguilar?
A No.

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Q At the time that you wrote this report, have you had a conversation with any of his family members?
A No.
Q At the time that you wrote this report, did you have a conversation with any of his case managers?
A No.
Q Okay. At the time you wrote this report, did you have any conversations with his healthcare providers?
A No.
Q All right. But you did review their records?
A Yes.
Q All right. Or, to put it differently, you reviewed all the records that the attorneys gave you to review --
A Right.
Q -- at the time you were asked?
A I asked for all of the available records.
Q And as far as you know, you got those?
A Right. But, obviously, I can't control what I get but...
Q Exactly. Because what was given to you, they stopped in, what, hold on a second.
A March, 2016.
Q March, 2016.

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A But I obviously knew that there was ongoing things so -- because he didn't make his appointment and I was -- I was told why and all that.
Q What were you told?
A He had had another -- he had a car accident, and he was in rehab or the hospital. I forget which one.
Q He had a car accident in October of 2016, right?
A Right.
Q Okay. So the records that you are reviewing, that you had reviewed in March, were the records only related to the injuries that were allegedly sustained as a result of the accident on October 11th, 2013, true?
A Which is -- yes, and which is what I was asked to do the life care plan about.
Q I'm sorry. What were you asked to do the life care plan about?
A About the injury in 2013.
Q Okay. Now, the costs in your life care plan, they are all anticipated costs, true? Future costs?
A Right.
Q All right. If there is something, for example, that he purchased in the past, if you included that in your future costs, it should be taken out,

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correct?
A Can you be more specific?
Q Sure.
If he purchased a device in the past, between October, 2013, and October, 2016, if you, in December, 2016, included a device that he already purchased and was using that didn't need replacement, it should be taken out of your life care plan, right?
A Potentially, but can you be more specific about which device you are referring to or just in general?
Q Yeah. Well, in general, because we will get to the specific devices --
A Okay. That's true.
Q Let's just -- okay.
A I mean, that's true. So I always try to find out what they have, because I'm not going to give them a brand-new wheelchair now if they already have just gotten one, for example. So we don't -- that's other information that we take into account.
Q Right. And, again, in this particular case, without the benefit of being able to conduct an examination or the benefit of being able to conduct an interview, you were somewhat limited, true?
A I -- yeah. I have to assume certain things.

Q The medical services and goods that are delineated in your life care plan, have you discussed the medical necessity of those with any of Mr. Aguilar's treating physicians?
A No. I have the capability of determining whether it's medically necessary. And, again, I am not doing bare minimum medically necessary. I am actually trying to prevent things and get him to the highest quality of life so...
Q Since you haven't discussed it with any of his treating physicians, is it safe to say that no treating physician has agreed with you and said the goods and services that you are calling for in your life care plan are medically necessary?
A I don't know if they have been asked that question so, no, but I don't know if they have been asked to outline what he is going to need for the rest of his life either, because they are not asked to do a life care plan, which is completely different than treating him on a weekly or monthly basis.
Q Right. And as I understand your purpose and why you are here, based on your education, background, and training, you are saying that the things in the life care plan are medically necessary, based on your opinions, right?

A Right, and based on what a life care plan is designed to do.
Q Okay. Now, at the bottom of Page 3, these are your four -- are these your four opinions or conclusions?
A Conclusions.
Q Conclusions?
And No. 1, we kind of touched on that already with the medical necessity of them. And in No. 1, you are limiting it to -- you are limiting your conclusions to whatever injuries that allegedly occurred as a result of the incident on October 13th, 2000- -- excuse me -- October 11, 2013, true?
A Correct.
Q Then your second conclusion, I will read it aloud and you read it silently, please. "Based on the known medical conditions, Mr. Gustavo Aguilar will have lifelong, progressive symptoms, physical impairment and subsequent disability which will require lifelong medical care of both conservative and surgical nature."
Did I read that correctly?
A Yes.
Q What are the "lifelong, progressive symptoms" that you are referring to?
A So based on his injury, which was a spinal

cord injury, there is certain things that go along with that. You -- you have -- the main things with spinal cord injury are spasticity, bowel and blad- -- bowel and bladder management, wounds, overuse of the upper extremity, pain, pneumonia, UTIs, infections, and any kind of complications that go with those things.
So that's kind of the symptoms, I guess, that -- because a spinal cord injury doesn't just stay the same forever. I mean, you will have -- you know, you could end up with kidney issues or urinary issues or skin issues because of that initial injury, so that's the things I am talking about there.
Q And the physical impairment, what are you talking about there?
A Kind of the same things, so the fact that he will be in a wheelchair. He is, you know, based on the October, 2013, injury, paralyzed from the waist down, unable to walk again. Impairment with transfers, he is not going to be -- there is age there, too.
So just because somebody can transfer themselves at 65, which I am not 100 percent sure that he could do, because he did have his daughter to help him, but even if he could do it at 65, it doesn't mean he is able to do it at 75. So you do take in age with an injury -- aging with an injury.

Q And what about the subsequent disability?
A So the disability is something that is not the person's impairment, but it's what is the outcome in life? What are they going to have to deal with?
He is going to have to deal with the fact he can't walk, he can't get in and out of places by himself. He -- you know, he was driving but -- you know, transportation issues, things like that. So it's the impact, basically.
Q And the -- and you said, "which will require lifelong medical care"?
A Right.
Q So --
A A spinal cord injury is not going away.
Q Right. And what this sounds like to me are those consequent circumstances that we talked about earlier --
A Correct.
Q -- true?
A Yes.
Q Impairment, disability, life expectancy adjustment --
A Right.
Q -- right? Which is in the methodology?
A Correct.

Q Okay. In No. 3 you talk about, "As a result of the injuries listed, there will not be an adverse impact to his life expect-" -- "on his life expectancy." And you cite to the third-party sources that we touched on earlier that you rely on, right?
A Correct.
Q Now, are there three third-party sources that you are relying on?
A No. It's the same.
Q It's just one?
A Yeah, yeah, it's just one source.
Q Okay. And does that one source, does it have a section in it that discusses adjusting life expectancy, based on Mr. Aguilar's diagnosis?
A No.
Q So Mr. Aguilar's diagnosis is T12 ASIA B, true?
A Right.
Q And what that means is, as you said earlier, he has essentially lost the use of his legs, his lower extremities?
A Right.
Q All right. Paralyzed?
A Right.
Q All right. Are there other sources that you

are aware of that reduce life expectancy due to paraplegia?
A Yes, there are.
Q Okay.
A There is spinal cord injury sources out there.
Q Why did you not use those, since Mr. Aguilar is suffering from a spinal cord injury?
A The reason I don't use those is -- first of all, I'm taking the life care plan into account. Second of all, those sources, specific journal articles or specific databases for spinal cord injury, those are a very specific group of patients.
And in my opinion, you know, Mr. Aguilar -- I don't know that he -- you know, there is no specific journal article or table for Mr. Aguilar, so I am looking individually at Mr. Aguilar. So I don't want to be -- I don't want the limitations of those studies or those conclusions kind of on him, so I try to make it as individual as possible.
Q Okay. And in making it as individual as possible, you should have considered the adjustment factors, right, the life expectancy adjustment factors, true?
A Based on what I reviewed and his injuries, I didn't feel like, at that point, that I needed to reduce

the life expectancy.
Q But my question, though -- well, let me ask it a different way.
Since you didn't feel like you needed to reduce the life expectancy or adjust the life expectancy, you didn't consider any of the adjustment factors that we agreed upon earlier that you should look at?
A Adjustment factors like?
Q Establish a baseline from a third-party source, consider the primary injury and its most likely impact, those factors that we talked about.
A So kind of going back to my thought process in that, based on what I reviewed at this -- at that time, I mean, I did say that I actually want to decrease it for other reasons now. But based on the fact that he, with the life care plan, will get optimal care and prevent any complications, I was comfortable using, you know, these life tables and not adjusting life expectancy at that time.
Q Right. But now, if I understand your earlier testimony, you are going to adjust it because he is quadriplegic?
A Right.
Q Okay.

A But not only that, because he is -- he is severely disabled currently. And the fact that he has ankylosing spondylitis and the fact that, you know, being on bed rest and being at risk for certain things, I believe that the life expectancy needs to be decreased now.
Q So the fact that he has ankylosing spondylitis, is that one of the factors that weighs on your decision to -- that now it's appropriate to reduce the life expectancy?
A Not only the fact that he has ankylosing spondylitis, because you can be pretty functional --
Q Yeah, not only. Not only.
A Not only but -- and I knew he had it before, but seeing him and realizing that he has pretty bad ankylosing spondylitis, kind of -- to kind of put it plainly. So seeing him was kind of one of the biggest reasons why I could see it decreasing.
Q So have you -- had you seen him before December 1st, 2016, and after that October, 2016, accident, you would have decided to reduce it then, true?
A Possibly, yeah. Possibly.
Q It would have been a lower number in your life care -- the number would have been lower had you been

able to look at him or examine him and interview him before you wrote your report on December 1st, 2016?
A Possibly. I can't really say for sure, because it really just depends. I mean, I -- I --
Q Well, the condition that he is in or the condition that he was in on January 26, 2017, would have been the same condition he would have been in on December 1st, 2016, right? I may have messed up the dates. Let me ask that again.
The condition that he was in on January 26, 2017, when you conducted your interview and examination, that was the same condition he was in in December of 2016, true?
A Yeah. I am not going -- I'm just not going to speculate on what I would have done if I would have -- there is a lot of "ifs" there. So I did what I did based on the information I had, and now that I have more information, I am doing this. So that's it.
Q Now, going back to Conclusion No. 2, what subsequent disability are you assuming that he is going to have?
A Contractures, spasticity.
Q Right, but --
A Bladder issues, wounds.
Q And that's based on what?

A The fact that he has a spinal cord injury.
Q Does he have any of those things now?
A I believe he -- I don't know if he has them today, but when I saw him, he had wounds.
Q Okay.
A And then he was due to have -- he was having renal stones or ureter tract stones and then due to have a suprapubic, because he had had UTIs and -- so he had -- he was having complications.
Q Right. Do you know if he was having those complications before October, 2016?
A I don't know.
Q You have reviewed the medical records, right? In the medical records --
A You know, he was having ongoing urinary issues. The wounds, I don't know if I saw anything about the wounds.
Q Right. In the medical --
A There were wounds initially.
Q Initially --
A Yeah.
Q -- but they healed, right?
A Right.
Q All right. And that's what the medical records showed you, the ones that you reviewed, that

ended in March, 2016, true?
A Right, but you understand that just -- once a wound heals, it doesn't mean that he is not going to get another wound. If you have a spinal cord injury, whether it's -- you know, actually the paraplegics end up getting -- can get up -- end up getting worse wounds because they are sitting so much, so they will be noncompliant with weight shifting and all that.
Q Excuse me, I'm sorry.
I understand that.
A Yeah.
Q But based on the records that you saw, you didn't see -- or that you reviewed, you didn't see any indication of that, did you?
A That he had on, like, wounds at this moment?
Q Yes, ma'am.
A Well, the last record I had was March so, I mean, let me just take a look here.
I mean, he had ongoing issues, as of, you know, 2016, of the neurogenic bladder, which is not going to be getting better.
Q Well, right now, we are talking about the wounds.
A Right. The wounds, the last thing that I saw in the records would have been January, 2014, wounds

from the Foley, and then prior to that...
Q So based on the medical records that you reviewed at the time you had -- that support your December 1st, 2016, life care plan, there was no mention of wounds after January, 2014, true?
A I believe so, yeah.
Q All right. So, again, you are making this assumption regarding subsequent disability, right --
A Yes.
Q -- based on the records?
A Absolutely.
Q Okay.
A With a spinal cord injury, the likelihood they are going to get wounds, pretty high.
Q Well, I understand that.
From January, 2014, though, until, we will say, October, 2016, when he had the subsequent incident, or accident, there is nothing in the records about wounds, is there?
A No.
MR. McALPINE: Objection. Assumes facts not in evidence.
A Not that I -- not that were in the records.
Q (BY MR. GREENE) Okay. And you have reviewed additional records since then, true?

A Right.
Q All right. And there is no -- so there is no treatment records to support the assumption of subsequent disability --
MR. GREENE: Object --
Q (BY MR. GREENE) -- prior to that October, 2016, incident?
A He had wounds on admission when he first had a spinal cord injury obviously and then --
Q I apologize. That was a bad question.
A Yeah, yeah.
Q Between January, 2014, and October, 2016, when the subsequent incident occurred, there are no medical records to support subsequent disability --
MR. McALPINE: Objection. Argumentative.
Q (BY MR. GREENE) -- correct?
A As far as the wounds, there are no record that I saw of him having any wounds. I don't know if he had any still. There are -- I don't see any evidence in what I reviewed that he did have. That doesn't mean that I am not going to -- just because he had a short period of time where he didn't have any, the individual is not -- it's great he didn't have wounds. It's great, but it doesn't mean that he is never going to have wounds in the future if he is a paraplegic, you know,

so...
Q So, in your opinion, two years and ten months is a short period of time with respect to whether wounds are going to show up?
A If he has got the rest of his life left? I mean, it's -- it's good. He didn't have ongoing problems, but I think with aging, you can't assume that he -- I think it would be irresponsible to assume that he was not going to have any wounds. I think...
Q Earlier when we were talking about adjusting the life expectancy and you explained why you did it --
A Right.
Q -- the way you did it, but with respect to methodology, it is commonly accepted for folks in your field to adjust life care expectancy based on the primary injury and its most likely impact on life expectancy, right?
A A lot of people use tables. A lot of people use those spinal cord tables. There are -- those tables are not perfect, though. That's all I'm saying. Those are a specific patient population. It doesn't take into account, you know, great care and, you know, all that stuff so...
People use it. I wouldn't say that -- I mean, every life care planner/physiatrist is going to do

things differently. Maybe you will find some that, you know, take -- they will take percentages off the life expectancy every time. I just like to be individual, and that's why I am, you know, paying attention to it now and wanting to decrease it a little bit.
Q I understand. That wasn't quite my question, though.
A Okay.
Q My question is: In life care planning and physiatry, as you mentioned, it is acceptable to adjust life expectancy based on the primary injury and its most likely impact on life expectancy, true?
A Yes, I would say that's true.
Q And it's also an acceptable methodology to consider the associated conditions and consequences and their impact on life expectancy, true?
A Yes.
Q And it is also an accepted methodology to consider preexisting injuries or newly developed conditions and their impact on life expectancy --
A True.
Q -- right?
A Right.
Q And it's also a commonly accepted methodology -- methodology in life care planning and

physiatry to isolate the specific individual and his unique risk factors that have been established by a physician, true?
A True.
Q All right. So simply because you did it a different way, that doesn't mean that's the only way to do it, is it?
A No, and I -- I don't know why you are trying to isolate, you know, me as -- I am giving my opinion in full, based on what I had at that time so --
Q Well --
A -- you can -- I mean, that's what everybody does. And I don't think it's fair to say that you -- that everyone does it, when we don't have everyone here.
Q Oh, no, no. I apologize if you interpreted -- I didn't say, "everyone does it."
My question was: The things that I just mentioned, they are commonly accepted methodologies for doing it, true?
A True.
Q Okay. Where are we at? Page 5. From Page 5 to 24, these are all of your reviews of the records, true?
A As of December 1st, yes.
Q I'm sorry. Exactly. As of December 1st.

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And if we go to Exhibit No. 2, which you provided at the beginning of the deposition this morning, as a supplement, this is a listing of all of the records you have reviewed since December 1st?
A True.
Q Actually, these are also records that predate the October 11th, 2013, incident?
A Yes, which is what I got after.
Q And what is the impact of the records that predate, if any?
MR. McALPINE: Objection. Too general.
Q (BY MR. GREENE) On your opinions.
A Nothing more than what I have said so far, so I did take that into account.
Q The ankylosing spondylitis?
A Yeah, yeah. And that was in the records that -- initial records, too. And I know that he had, you know, abnormalities on spine imaging and everything.
Q If we turn to Page 28 in your report, this lists other documents that you reviewed?
A Right.
Q And, again, these are the documents that the attorneys gave to you --
A Right.
Q -- at the time, true?

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A True.
Q On -- or in, rather, Exhibit No. 2, I don't see any other documents that you were provided. Were you --
A Because that means that -- let me just show you here.
So in the life care plan, "other documents" is things that were not necessarily in the record review, like billing and things like that. They are not going to summarize that. In "other documents" here, it doesn't kind of delineate other documents, but there are -- they don't break it up that way, but as far as, like, from, let's see, anything that is not medical, that will be considered kind of "other documents," like CVs from the other experts, reports from other experts, W9, those things. Those are in addition.
So even though those aren't reviewed, I also reviewed those because they are listed here.
Q Is it common for you to review a deposition?
A Yeah. I definitely do that.
Q Because if you can't interview him --
A Let's say half the time, about.
Q We are talking over each other.
A Sorry.
Q That's okay.

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If you can't interview him, you can't examine him, and you don't have an intake form, if a deposition is available, it should be sent to you, correct?
A I would say it's about -- half the time, it's there. I don't specifically ask for depositions, but if it's there, I will -- I obviously review it.
Q Yeah, no. And I am not saying you ask for it, because you don't know if it's there or not, true?
A Right.
Q But if you don't have any other source of subjective data -- the intake form, the interview, the physical examination -- at least you can review a deposition and you know what the man is testifying about, with respect to whether he has improved, whether his condition is deteriorating, what devices he is using, how is he progressing?
A Right.
Q You should be able to gather that from the deposition, right?
A I can do that, yeah. I mean, I will be happy to review it if he has one. I don't know if he has one.
Q Yeah. And that would be useful information?
A Yeah.
Q Right. Actually, he does have one.
A Okay.

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Q He was deposed before this October 11, 2013, incident -- or '16. Let me back up.
A Okay.
Q So many dates.
The October 4th, 2016, incident, Mr. Aguilar was deposed on September 9th -- September 19th, 2016. You didn't know that?
A No. I mean, I -- it's not abnormal that he is deposed. I just didn't know when he was.
Q Well, we would hope he would be deposed in a lawsuit, true?
A Right.
Q All right. So -- but that deposition would have provided you with information regarding his condition prior to the subsequent accident, correct?
MR. McALPINE: Objection. Calls for speculation.
A It -- yeah, it could have.
Q (BY MR. GREENE) It could have.
A I mean, I don't know what was in there.
Q But you have never seen it?
A No, I have not.
Q All right.
A Happy to review it before I do a subsequent report.

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Q I wish you would have reviewed it before you did the first one, but that's neither here nor there.
Going back to the methodologies for adjusting life expectancy, if you would have used the methodologies that we discussed earlier, regarding --
A Can you be more specific --
Q Sure.
A -- sorry, on "methodology of life expectancy," because I --
Q No. I said, "methodologies regarding adjustments to life expectancy."
A Right, so...
Q Had you looked at the tables that you said are available --
A Yes.
Q -- regarding spinal cord injuries?
A I am aware of the tables, yes.
Q Had you considered his associated conditions and consequences, had you considered preexisting conditions and consequences or newly developed conditions, had you used that methodology, how would that have affected your opinion?
MR. McALPINE: Objection. Calls for speculation, incomplete hypothetical.
A So as far as -- decreasing any life expectancy

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is included in my methodology. How I do that, there is no -- that's individual to whoever is decreasing it. You know, you can have Life Care Planner A over here. They may do it one way, because that -- as long as you are kind of doing it the same way every time, there is no specific outline for saying, "you must decrease life expectancy if A, B, C, D." That is individual to the expert.
So as long as I am doing it the -- it's almost like the way I do costs. It's like as long as I'm -- the IARP and the organizations that exist oversighting life care planners, they are actually very general, as far as the methodologies, but they do say, as long as you have a way that is repeatable and you do it that way every time.
So I just kind of disagree with the fact that you are saying, oh, there is these methodologies for life expectancy adjustment out there that you are -- well, I am actually following the methodology that I always follow in doing a life care plan, which includes am I adjusting or am I not? And at --
Q Right.
A -- that point -- and at the point of -- in January -- or, sorry, in December, 2016, I did not want to adjust life expectancy. I am not going to just, you

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know, prematurely decrease it without knowing, like --
Q Okay.
A Based on more information I may have, yes.
Q So in December, 2016, you knew he was paralyzed, right?
A Right.
Q You knew he was diagnosed as T12 ASIA B, right?
A Right.
Q Using a chart, you could have reduced the life expectancy, true?
A A chart based on what, though? That's the -- that's where --
Q Based on the spinal cord studies that you talked about earlier.
A Right, and -- but I don't have a study for Mr. Aguilar that has followed my life care plan, so that's kind of where I am disagreeing with you.
Q You knew that he suffered from ankylosing spondylitis, right?
A Yes.
Q You could have reduced it for that, right?
A Potentially, but not --
Q Well, you're --
A You have to account for everything, so I

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didn't and -- you know, at that time, I didn't.
Q Why didn't you?
A Because I didn't feel like I had the information to do it, and I am -- I don't typically just reduce it to reduce it. I really take it seriously to reduce the life expectancy or to mess with the life expectancy at all, and it's not -- it's just I want to be sure.
Q Do you know if Mr. Aguilar has gained any weight since the October 11, 2013, accident?
A I don't know specifically right now.
Q Do you know what his weight was when he showed up to the hospital on October 11, 2013?
A No. I don't have that information right now.
Q Do you know what his weight is now, or as of January 26, 2017?
A Can I see my physician consultation, please?
Q (Counsel tendering to Witness.)
A It was around 216 pounds. But that was by history, so I didn't actually weigh him myself.
Q Okay. So you don't know if he has gained weight or lost weight?
A No.
Q What happened to your flash drive?
MR. McALPINE: Can we go off the record

for a second?
THE VIDEOGRAPHER: Yes, sir. We are going off the record at 12:32 p.m.
(RECESS FROM 12:32 P.M. TO 12:43 P.M.)
THE VIDEOGRAPHER: We are back on the record at 12:43 p.m.
Q (BY MR. GREENE) Ma'am, with respect to the four conclusions that you have come up with in this case on pages -- reflected on pages 3 and 4 of your December 1st, 2016, report, have you told me everything that you have relied on for those --
A Yes.
Q -- to support those conclusions?
A Yes.
Q And other than the medical records, every document that you relied on in formulating the conclusions in the December report are identified in the report itself, true?
A Except for maybe the intake but, yes. The intake form was not -- I don't know if it was identified in the plan, but everything else would have been. I mean, I guess, technically it's part of his medical records so...
Q We talked about your continuing legal educate- -- I'm sorry -- your continuing education

earlier?
A Yes.
Q Did you take a class entitled "Certified Life Care" -- "Certified Life Care Course" online? Have you ever heard of that?
A It's through UF. It's through University of Florida.
Q Uh-huh.
A There is six modules. Five of them is online. The sixth one is in person. That's the course I took for my pre-life care planning.
Q And was there a section on spinal cord injuries?
A Yes.
Q Is that something that you relied on in this case?
A I didn't rely on anything specifically. I mean, I rely on my education, training, experience, and that does include -- but I didn't go back to any documents that I, you know, specifically a course I went to or anything. This was my opinion.
Q With respect to your assignment in this matter, what were you told to render opinions on?
A His future medical needs and the cost of those items, as well as the diagnostic conclusions that would

bring out those future needs. And that's -- so I was asked to do a life care plan. That's basically what a life care plan is.
Q And is it fair to say that your opinions are based on his medical diagnosis?
A Yes.
Q And that's the T12 ASIA B that we have talked about before?
A Right.
Q Can you break that down? Tell me what that means, "T12 ASIA B."
A T12 is basically the thoracic spine, the level, which vertebrae neurologic level that he is -- that he was kind of determined to be after his injury. So that's just kind of where, along the spine -- cervical, thoracic, or lumbar -- that he is. So he is a lower thorac- -- at that time, he was lower thoracic.
He is an incomplete injury. And it goes through A through E, and A is a complete injury. Anything other than A is an incomplete injury. What that means is, do they have anal sphincter and tone. So if they are a complete injury, there is no sensation there. There is no motor control in those segments, in those sacral -- lower sacral segments, and that makes him an incomplete -- or, sorry, a complete.

An incomplete is basically -- a B is basically close to a complete, but he has some sensation in lower extremities or sacral segments. So it's just a way that we determine -- because based on what level he is, that's that ASIA scale, that helps us determine what his functional status is going to be later on.
It's not, you know, for sure, but, you know, we know certain things about certain levels, certain things that happen to them. Complication-wise, certain functions that they will be able to attain.
Like, for example, I am not going to, you know, start rehabbing somebody who is a C5 to start, you know, walking independently, not at this point anyway. With the medical technology, maybe in the future, but -- so it just helps us classify them so we can appropriately care for them.
Q And that diagnosis was also considered in your opinions?
A Yes.
Q All right. And ultimately in this case, as a life care planner, the ultimate opinions are the future costs; is that fair?
A Right.
Q Before we talk about that, if you would, turn to Page 46 of your report.

A Uh-huh.
Q Are you already --
A Yeah, I am here.
Q You have mentioned this term a couple of times. What is "comorbidities"?
A It means medical problems that he has as well, kind of other things that he has going on kind of unrelated to this accident.
Q Do those other medical problems -- or, excuse me. Can those other medical problems affect his life expectancy?
A Those things alone, I wouldn't say, "Oh, yeah, for sure decrease the life expectancy." Those are not impressive enough to me to say for sure. Can they? Could he have high blood pressure untreated, get a stroke, and, you know, have a bad outcome? Yeah, he could die. I mean, there is things that obviously -- but I didn't decrease it based on these.
Q Well, and let's talk about those. The comorbidities that you have identified are ankylosing spondylitis, true?
A Yes.
Q Impaired mobility?
A Yes.
Q Hypertension?

A Yes.
Q And hyperlipidemia?
A Right.
Q And you didn't consider any of those in adjusting his life expectancy when you authored your report in December -- on December 1st, 2016?
A I did consider them. I just did not make the conclusion that I was going to decrease it.
Q You concluded that none of those warranted an adjustment to his life expectancy?
A Right. At that time, no. And, again, I do take decreasing life expectancy pretty seriously, because I feel like I really would need to know why I am doing that. I can't just arbitrarily, you know, do that.
Q Even when he -- when a patient, such as Mr. Aguilar, has four different factors that could affect his life expectancy, you still don't consider that worthy of adjusting life expectancy in this case?
A No, because I didn't really see a lot of evidence to say, "Okay, for sure he is having a lot of problems with this." I mean, he was having -- he was taking his blood pressure medication. He was taking his other medications. He was under, you know, doctor's treatment for ankylosing spondylitis. So did I want

more information about that subsequent injury, which I had no records on? Yes, but at that time I didn't have those.
Q Now, in 5.2, "Diagnosis Requiring Ongoing Medical Attention," No. 5, "severe traumatic brain injury"?
A Right.
Q He sustained a severe traumatic brain injury?
A So, basically, based on history and based on his GCS, his Glasgow Coma Scale, at the time of admission -- I just want to see exactly what that was -- that's all -- all you need to say somebody has severe TBI is: What was their GCS?
He hit his head, according to history, and then GCS was 3. That's -- that's the lowest you can go on that scale, so something happened to him. The GCS was severely affected, so without saying -- and I didn't, you know, go and go crazy on that. I just said, "We need to look at that."
I know that when I saw him, he was walking, talking, all that stuff, but according to what I had at that time, when I see GCS of 3, even if he is fully recovered, he is severe. He will always be a severe.
Q A 3 is he is unconscious, right?
A Right.

Q Okay.
A With no movement, no eye opening, anything.
Q Okay. This says, "ongoing medical attention." What medical attention has he received since October 11, 2013, regarding a severe traumatic brain injury?
A Well, he had rehab, so that inherently includes -- he had a neuropsych evaluation inpatient when he was evaluated --
Q When was that?
A -- initially. Back after the initial injury, so it was November, 2013.
Q Okay. Since November, 2013, what medical attention --
A I don't believe he has had any, yeah.
Q -- what medical attention has he required related to his severe traumatic brain injury?
A He has not had any specific, you know, TBI treatment. He wasn't, you know, on any ongoing speech or anything like that. What I am interested, when I did this report, was I want to make sure we assess it correctly. And then beyond that, I did not have anything major for him.
Q So there is no ongoing medical treatment for severe traumatic brain injury --
A Well, if you want to go through --

Q -- is that fair?
A No, it's not, because he had -- after I saw him, he does have memory issues. It's a little unclear about when those started happening. He couldn't really tell me. I don't think that -- I want to go through, you know, line by line to make sure that I am not forgetting anything so...
So the only thing that I would include would be -- which can be related to the TBI, would be the individual counseling, which can be tied to the TBI, and then as far as treatment for the severe TBI, and then the neuropsych evaluation.
Q What treating physician has said he needs treatment for the TBI?
A I don't know if anyone has.
Q What treating physician has said he needs to undergo neuropsych evaluations on a regular basis related to a severe traumatic brain injury?
A I don't know that anyone has. I only -- I didn't say, "on a regular basis." I only want him to do an evaluation one time as an outpatient, because they are always -- they do evaluations initially and they are not as lengthy, so I would like him to get one now. And that's -- there is really not a lot of ongoing treatment, other than the supportive care, you know, for

the spinal cord injury, which is kind of unrelated to the TBI.
But, again, I am outlining all the medical diagnoses that I see. Whether or not they need a little or a lot, that's kind of -- you have to look at the rest of the plan.
Q Right. But with respect to the TBI, I am trying to figure out what medical evidence you have to support that, other than the initial treatment where he had a Glasgow Coma Scale score of 3.
A That's all I need to say he has a severe TBI, and I --
Q Right.
A And the only ongoing treatment I am saying is: "Can we take a look at that one more time?" That's pretty severe to have a GCS of 3 and to say you have no deficits. I am very skeptical of anyone who says -- I don't think anyone has. But to say he has no deficits, I just disagree with that, because I don't think they have looked hard enough. So I'm saying, "Let's get him a neuropsych eval and just see." I haven't outlined any future, you know, cognitive, anything. I am just saying, "Let's look."
Q So if I understand, he is three and a half years removed from this incident where he hit his head,

and there is no treating physician who has identified any objective factors to support that he has a severe traumatic brain injury that requires ongoing treatment. Despite that, you just want him to have a neuropsych eval, just because?
MR. McALPINE: Objection. Assumes facts not in evidence.
A I -- I mean, the fact -- I cannot comment on if they have picked up on anything or not. I know that after I saw him -- first of all, I think it's prudent for him to have that done outpatient, whether or not anyone has said it or not, because I think that they are going to find things that he is not saying or that they just haven't asked.
Just -- because if you go see a PM&R doctor for half an hour, they are not going to delve into all your cognitive issues. And he may not -- when I -- so, then, when I saw him, everything was pretty good, speech was good. He reported to me that after the accident, he had difficulty with expressive parts, not necessarily speech, but more dexterity, which was fine at that time, but writing and using his hands expressively. So that's a cognitive issue.
Q (BY MR. GREENE) After what accident?
A The first accident.

Q Because after the first accident, he was sending text messages. You know that?
A Yes, yes. And he --
Q After the first accident --
A -- he said that it wasn't as good.
Q -- he was driving?
A Yeah, I got it.
Q Okay.
A He just said it wasn't as good so --
Q Right.
A -- it just kind of backs up the fact that I think he should have a one-time evaluation, which I think is prudent for him to have.
Q And you are basing this on an interview that you conducted with him after the second accident?
A No. I am basing it on GCS of 3.
Q Well --
A It hasn't been looked into.
Q Right. Earlier you said you test- -- you interviewed him and he expressed to you some cognitive issues, some memory loss issues.
Do you remember saying that?
A Yes, sir.
Q Okay. And that's based on an examination that you conducted on January 26, 2017, correct?

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A Right. And it also backs up what I suspected before, that I am sure there is something, right? So I am not saying that I based this on my interview. I am saying that --
Q Well --
A I am saying that he likely has something. I just don't think anybody has found it yet. The fact that he had a GCS of 3 deserves a neuropsych eval. That's all I said. I am not saying he needs, like -- I'm not saying -- assuming that he has anything or that he is going to need future treatment at the time of this life care plan, so it's reasonable to -- for him to have a neuropsych eval. Then --
Q Okay.
A -- after the life care plan, I saw him. I said, "Oh, he actually does have cognitive deficits" --
Q So --
A -- "by history." So for sure he deserves the neuropsych eval. So I'm just saying that my visit kind of backed up what I thought and --
Q Right.
A -- what I recommended.
Q But that visit was after an incident -- an accident, a car accident, which left the man a quadriplegic, right?

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A Right, that's true.
Q What was his Glasgow Coma Scale after that accident?
A I would have to look. I am not sure.
Q Have you seen it?
A I would have to look.
Q Okay.
A If I can see the...
Q Do you know, sitting here today, whether he was unconscious, as a result of that accident?
A Can I take a look at the...
Q I don't know which record you are talking about.
A It's the record review that was subsequent to the...
But it doesn't change the fact that he deserves a neuropsych eval from the first accident, you know what I am saying? So -- and, plus, he gave me the history that he had memory issues and expressive issues after. It doesn't mean he wasn't texting. It just means that he wasn't what he used to be so...
Q And when we are talking about the neuropsych eval, we are talking about the cost -- the future care?
A Right.
Q Okay. And we will get to all of those. All

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right.
A Yeah. Glasgow Coma Scale of 15 on the 2016 so...
Q Okay. Let's go through your costs. Well, actually, before we do that, Section 6.
A Yes.
Q Those are the vendor surveys, right?
A Yes.
THE REPORTER: I'm sorry. The vendor what?
MR. GREENE: "Surveys."
Q (BY MR. GREENE) And this is, you testified earlier, something that you did not perform, right?
A No, not the initial research.
Q Okay.
A I rely on an assistant, and then I go over everything.
Q How do you know -- excuse me.
How are the vendors surveys conducted?
A So basically we -- we maintain a database at PLCP that is updated, you know, every six months, or more often, to include prices in specific areas. So for his case, prices in Houston. And then if we don't have a price for a specific item, we will -- I will have the vendor specialist call or research that specific price,

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because they can either do that online in certain databases that are available to the public or by calling a specific office and asking for a price or a specific rehab facility and asking for a price. So it's a combination.
Q And you are relying on someone -- what's his name again?
A This would have been Kristin or somebody -- I believe it was Kristin, the vendor person.
Q Do you know why Kristin is no longer there?
A No, I don't.
Q All right. And what's the purpose --
A She was excellent. She was excellent, by the way.
Q What's the purpose of the vendor survey and the prices?
A So basically in the methodology outlined by rehab professionals in specific journals -- the Journal of Life Care Planning is one of them -- the correct methodology for obtaining prices, they are not -- they are pretty general about it, but -- and I think that PLCP actually does a better job than just their general recommendation in the general life care planning, but they say that it has to be specific to the person's geographical location and more than one price should be

obtained, if possible, so basically you average it. And then, you know, obviously it would have to be current prices.

So they ask that you follow those specific rules when you are obtaining prices. It's a guideline basically, and then that's exactly how Physician Life Care Planning does it. They just make sure, you know, a little bit more stringently making sure the prices are up to date.

If -- you know, specifically, if I have a question on things, they will double-check. They will call, they will outline exactly what's going on, so I am very confident in the vendor survey.

Q How have you individualized your life care plan to Mr. Aguilar's needs?

A As far as what?

Q In general, the entire life care plan. How is it individualized to the injury that he received and the future needs that you are saying he requires?

A So when I start a life care plan, I think about what he has and how he has to go about his daily life. All right? So I have to know what doctors he is going to need to see based on his injuries. I have to -- so I go through each category of care to optimize everything, right?

What medications is he going to need? Do we need to monitor the effect of those medications? What devices is he going to need to maximize his function? What type of evaluations have not been done that need to be done that can help us further, you know, outline what his injuries are and how we can help him? What are the specific interventions that he will need in the future, if any?

In his case, specifically suprapubic catheter placement to prevent any future wounds and, you know, neurogenic bladder issues. So I go through and I look at him going through his daily life and say, "What does he need to do that?"

Q And in looking at the -- what you are projecting, the physical medicine and rehab plan [sic], why is that --

A Pain. Pain. Or pain.

Q I'm sorry. "Physical medicine and rehabilitation/pain management."

A Uh-huh.

Q What is that?

A It's basically an office visit with a PM&R physician who knows about pain as well or who could be, you know, certified in pain management as well, because he has pain issues.

Q Well, he is provided medication for pain, right?

A Right, but you need somebody to manage. It's an office visit with a physician.

Q And what's the basis for the recommendation that he do this four times per year?

A So basically that is -- in actuality now, he is actually going to need more visits than that, but based on the injuries that he sustained in 2013, my opinion is that to manage and maintain ongoing rehab needs, medications, you know, specifically, like, refills, equipment, managing symptoms, like spasticity, pain, contracture, wounds, et cetera, this is kind of like the primary care doctor for the spinal-cord-injured individual.

Q My question, though, is: What is the basis for that? What is the basis for this recommendation that he is going to --

A Education, training, yeah.

Q -- need this four --

You've got to -- you have got to let me finish.

What's the basis for your opinion that he is going to need to do this PM&R and pain management four times per year?

A That's based on my education, training, and experience as a PM&R doctor. That's the -- that's the minimum of the follow-up, if somebody is having ongoing issues and -- you know, quarterly basically.

Q So is any of this based on any input from Mr. Aguilar?

A No, no. This is --

Q His subjective statements to you?

A No.

Q Okay. There is nothing -- is there anything that he could have said in an interview that would affect whether he will need this service?

A I mean, first of all, I did this before I saw him, but in the future, I mean, just because somebody says, "I want to go every month to the PM&R," I am not going to do that. It's reasonable that they can go every quarter. They can make phone calls, if they need to, for other problems.

Q Right. And that's -- can you point me to anything that I can read that says four times a year is reasonable?

A I think you can look at common practice. I don't have a journal that says a spinal-cord-injured patient -- they should, at a minimum, be seen once a year. That is definitely -- there may be literature on

that, but as far as what I have seen in practice and the actual what happens to people and how often they end up coming to see a PM&R, it's basically their -- their primary doctor for everything, I mean, because they will end up managing, you know, other things as well and any complications from the spinal cord injuries. So it is kind of a commonplace...

Q Well, you say it's "commonplace" and what you have seen in practice. How long have you been practicing?

A Well, including residency, since 2009.

Q Yeah. Just practicing, not including your residency.

A I don't think that's fair, because we saw a lot of spinal-cord-injured parents.

Q Okay.

A Yeah.

Q Since residency in 2009, since you have been a licensed physician, how long?

A How many patients?

Q No. How long? How long have you been a licensed physician?

A Oh, well, I had my New York license since 2011.

Q And your Texas license?

A 2012. I don't have my New York license anymore, since I moved.

Q All right. So when you say what you have seen in practice as, we will say as a licensed physician, you are talking about four and a half years of practice? Not even four and a half years. Four years and a quarter in practice, right?

A Right.

Q The orthopedic spine surgeon -- oh, I'm sorry. Before we leave the PM&R/pain management, we know now that the duration is wrong in this --

A Yes.

Q -- estimate, right?

A I would like to change the duration, yes.

Q To what?

A So I have not come to a final decision on what percentage I will decrease it, but I am thinking at least 10 percent decrease of life expectancy, so that would be about two years off of the total.

Q What are you going to base your decreased life expectancy on? How do you arrive at 2 percent?

MR. McALPINE: Objection.

A Two years. Two years.

Q (BY MR. GREENE) Oh, 10 percent, I'm sorry.

A Yeah, 10 percent.

Q How do you arrive at a 10 percent reduction in life expectancy?

A Again, that's kind of -- we talked about that already, as far as individualizing it to Mr. Aguilar, based on his injuries, based on, you know, now he has the cervical -- the tetraplegia as well.

So I -- since last night, I haven't had enough time to really kind of come to a full conclusion on that. I am just saying at least 10 percent. And how am I -- you know, I would actually like to see how he is doing functionally, because I think when I saw him, he wasn't doing as well as he could be doing.

Q Well, my question is: When you are talking about a 10 percent reduction, what is the -- like, what are you relying on? What document? What periodical? What -- what written something that we can look at that says you reduce life expectancy by 10 percent if you have a person in Mr. Aguilar's condition?

A I am not aware of any article, you know, specific to his specific -- all of his specific things. Unfortunately, he doesn't -- there is no article written about Mr. Aguilar, but based -- it's based on my education, training, and experience, as well as the literature that's out there, so that's -- you know, I do want to also look at, you know, if there is any good

data on, you know, spinal cord injury, subsequent injuries, ankylosing spondylitis. I just haven't come to a full conclusion on the percentage, but obviously it's based on education, training, experience, research.

Q No, I understand that. So what is the methodology that you are using to arrive at a 10 percent reduction in life -- life expectancy?

MR. McALPINE: Objection. Assumes facts not in evidence.

MR. GREENE: She said she is going to reduce it.

MR. McALPINE: No, no, no. Just the 10 percent. She is sort of...

MR. GREENE: Okay.

MR. McALPINE: She said it wasn't final, right? Did you get that part? Okay.

A Yeah.

MR. GREENE: Not really.

A No. I said at least 10 percent, based on his injuries, based on my education, training, experience. That's it. I mean, and I'm aware of the tables.

Q (BY MR. GREENE) So it could be more?

A It could be more. I am aware of the tables. I am aware of, you know, the spinal cord injury tables decrease a cervical way more, so I want to just look at

it very carefully.
Q Okay. And do you know the basis as to why the spinal cord inj- -- the spinal cord injury table reduces it way more than 10 percent?
A Yes.
Q Why?
A Complications.
Q Okay. Well, why aren't you reducing it consistent -- well, let me back up.
A Well, I am. I am taking my life care plan into account.
Q Let me back up.
The spinal cord studies, the spinal cord chart that reduces life expectancy or adjusts life expectancy based on the injuries, that chart is based on studies that have been conducted, right?
A It's based on people with spinal cord injury that are participating in the studies.
Q Right.
A My problem with the studies is that it cannot include everybody so...
Q Are the studies peer-reviewed?
A Yes. I mean, this is actually a table, so, yeah, they are peer-reviewed.
Q Okay. So they are accepted by the medical

community?
A Yes, but I think that you are missing my point as far as why I -- why it's dangerous to just rely on a chart that Mr. Aguilar may or may not be included in, so I am tailoring it to him specifically.
Q Okay. Well, so a chart that is supported by empirical data and that's been peer-reviewed, the methodology to reach those numbers for adjusting a life care plan, they have been accepted by the medical community, right?
A Yes. And what's also --
Q Well, let me finish my question. Let me finish.
But you are going to reduce the life care plan -- or, excuse me -- reduce the life expectancy by a minimum of 10 percent. Can you tell me what statistical information or empirical data that you are relying on for a reduction or an adjustment in life expectancy of 10 percent?
A I am -- there is no study, again, about his specific things, but I can tell you -- no, no, let me finish, too.
So what I can tell you is that I rely on that specifically. I look at that when I am thinking about, okay, how much should I -- how much does a cervical, you

know, tetraplegic normally live? But what about Mr. Aguilar? He is going to have optimal care. There is no study that talks about that. I mean, I wish there was, but there isn't.
And if you ask if he -- I want to talk -- one more thing. If you ask a PM&R in practice, okay, are there tables out there? Are there statistics out there? Yes. Does that mean that Mr. Aguilar is going to follow them exactly? What if you give him optimal care? He is going to do much better than what the tables show.
So that's what I am going on. And, unfortunately, there is no table that I am aware of that is, you know, pertinent to Mr. Aguilar. That's why I have been asked to look at everything for him and say, "What is your opinion?" Since I do have the capacity to make that opinion, it is my opinion, what I believe the decreasing life expectancy would be.
MR. GREENE: Okay. Objection, nonresponsive.
Q (BY MR. GREENE) My question, ma'am: What is your -- okay. Let's back up.
The tables, the National Spinal Cord Injury Statistical Center, are you familiar with the table?
A Yes.
Q Do you disagree with the table?

A No.
Q But you disagree with using the table?
A I think it's problematic to use a table only for Mr. Aguilar.
Q Okay. But in arriving at your life expectancy of 19 years, you did rely on a table, correct? You relied on the --
A A table --
Q -- life expectancy table --
A A table.
Q -- yes?
A Another table for general population, yes.
Q Right. And you relying on that table was sufficient to arrive at your opinions, correct?
A That is kind of generally-accepted methodology for life care --
Q Okay.
A -- planning and with -- you know, obviously we can't give an exact number of years. I mean, he could die tomorrow from something else but -- but we have to rely on something, so that's what we relied on.
Q Okay.
A I am just not comfortable relying on one specific table for him when I have been asked to look at everything and make that opinion. So I think it's more

reliable for me to look at everything that I can specific to Mr. Aguilar, including any studies and tables that are out there, but --

Q Well, I guess --

A -- then you don't need a life care plan if you can look at a table.

Q All right. We talked about this earlier. The confusion that I am having is you just said you are not comfortable relying on one specific table, right?

A For life expectancy, no.

Q Okay. So your conclusion in No. 3, that as a result of injuries listed here, there would not be an adverse impact on life expectancy, you relied on one table for that conclusion.

A Right, but not for decreasing his life expectancy. I am not going to rely on one table with regards to one injury. I think that the tables are not equal, if you want to talk about --

Q No, no.

A -- comparing one table to the other because --

Q I don't want to talk about them right now.

A Okay.

Q If I want to talk about it, we will definitely get into it, but in your -- what I do want to talk about is your conclusion where you said, "adverse impact."

The adverse impact will be a decrease, right?

A Now that -- in the deposition you are saying that I said that or...

Q No. In your opinion, your Opinion No. 3 on Page 4.

A No decrease, I said, in my opinion.

Q Right. "As a result of the injuries listed, there will not be an adverse impact" --

A Right.

Q -- right?

So in arriving at no adverse impact, you relied on this one table?

A Right.

Q Okay.

A Because I am assuming he is general population, and in order to do a life care plan, I have to have some number of how much he has left to live.

Q Right. But we know he is not general population, don't we?

A Right, but I don't know what the number is going to be. So at the time I did this report, I didn't know what that would be, because I didn't feel like I had enough information to make that conclusion, because we would be sitting here talking about something totally different --

Q I'm sorry. Which conclusion?

A The decrease.

Q Oh.

A So I want to wait until I get more information to make a decrease. That's --

Q What other information do you need?

A Well, I saw him, right?

Q Uh-huh.

A I had -- now I have subsequent records. I don't think I have had adequate time to, you know, tell you the exact decrease that I am coming to. I would be happy to include that in my supplemental report.

Q Okay. And you saw him on January 26, 2017?

A Right.

Q Right.

The table, the National Spinal Cord Injury Statistical Center's table, again, that's one that everybody -- not "everybody," but people use to support their adjustments to life expectancy, true?

A They do. Yes, that's true.

Q Are you aware of any study or data that says that the National Spinal Cord Injury Statistical Center table is not acceptable to use when adjusting life expectancy?

A I don't think there is a study that's

disproving it, no.

Q All right. You -- if I understand your testimony, you don't want to use it or you haven't used it because it is not individualized to Mr. Aguilar; is that correct?

A That's one of the reasons, right.

Q But the fact is, as you said, the table takes into account folks with spinal cord injuries who are participating -- participating in a study to arrive at data, empirical information, that can be peer-reviewed, right?

A That's true, yeah.

Q All right. And so the numbers in this table have been peer-reviewed, yes?

A That's right. I am just saying that I don't -- you -- with a study -- medical school, residency, you go -- you read -- you do journals every week, right? So you talk about the inconsistencies or the problems with the study or the limitations of the study. And that's what I am trying to get at here with saying, well, relying on just one table, this is not, you know, the end-all be-all of Mr. Aguilar.

I think that if you, in my opinion, follow a life care plan where he has adequate care, I think that he can, you know, kind of go against, a little bit, what

the table is saying.
And optimal care is not what's taken into account in all of those patients in that study, because you have patients who have horrible things happening and not so horrible. It is a mix. I just -- I am just saying that he doesn't necessarily -- I don't want to be tied to that one table.
Q Right. But what you are essentially doing then, because you -- if I understand your testimony, you are relying on the life care plan to essentially say, "His life expectancy may be greater, may be less, but I am going to give him this life care plan and if he follows it, I am going to maximize his time here on earth"?
A Correct.
Q All right.
A That's -- you got it.
Q But in order to arrive at the numbers for the future medical, in order to arrive at the future medical treatment, the life expectancy adjustment is a factor that you consider when reaching that number. You don't do it backwards, do you?
A No.
Q Okay. So that's what I am trying to get at here. You are saying that you are going to rely on the

life care plan to increase his life expectancy, but in order to know what the life care plan is, you have to adjust the life expectancy based on him, true?
A True.
Q You are just not willing to adjust it based on a table --
MR. McALPINE: Objection.
Q (BY MR. GREENE) -- that decreases life --
MR. McALPINE: Misstates prior testimony.
Q (BY MR. GREENE) -- that decreases life expectancy?
MR. McALPINE: Objection.
A I am not only going to rely on the table.
MR. McALPINE: Misstates prior testimony.
A The table is referenced in my life care plan. I am aware of the table. I am just saying that I am not only going to use that table. I think that there is other things that we have to consider. It is my opinion. It is my opinion. There is no study for Mr. Aguilar, so that's it. I mean, it's -- I am entitled to my opinion about it.
Q (BY MR. GREENE) But there are no --
A Medical doctors and, you know, people doing life care plans, it's -- being a physician, there are kind of -- we are one of the only people who can say,

"Okay. Well, I think the life expectancy is going to be lower because of this, this, this."
So we don't just take into account a table. You don't have to be a doctor to just read a table, so that's -- it is my opinion.
Q Why did you not reduce the life expectancy before?
MR. McALPINE: Objection. Asked and answered.
A Like I said before, I don't feel like I had adequate evidence to, for sure, say that we were going -- he is going to need a decrease. I knew that there was something going on, but I was expecting to see him. And I know I can amend it, but I'm not -- like I said, I do take it very seriously to decrease the life expectancy.
Q (BY MR. GREENE) Orthopedic spine surgeon, is there something in the medical records to indicate that he needs to see an orthopedic spine surgeon as often you are saying he needs to see one?
A Once every three years, so that's three visits in the rest of his life. He has had a -- the reason for his spinal cord injury was, at that level, a worsening or a fracture at that area, so I think it's prudent for him to have a visit to follow up and monitor that.

Q Is there any -- are there any medical records to support the fact that some doctor who he is treating with has said he should see an outpatient [sic] spine surgeon as often as you are requesting he see him?
MR. McALPINE: Objection. Argumentative.
A I don't believe --
MR. McALPINE: Asked and answered.
A I don't believe that he has been asked, or I don't believe that his treating doctors have been asked, how many times in the rest of Mr. Aguilar's life do you think he is going to need to see me, because they are not doing a life care plan.
Q (BY MR. GREENE) Ma'am, have you reviewed the medical records?
A Yes.
Q Okay. Has any treating doctor, in the medical records that you have seen, recommended that Mr. Aguilar see an orthopedic spine surgeon once a year?
MR. McALPINE: Objection. Asked and answered, argumentative.
A He saw a spine surgery initially, right?
Q (BY MR. GREENE) Uh-huh.
A He has issues with that area. That's the area that he is -- that he had the paralysis from initially. It's prudent in my mind and in my opinion for him to

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have follow-up and monitoring of that specific area.
Whether or not the fact that some treating doctor, who is looking at this patient for 15 minutes, says, you know, "Oh, by the way, I think you should go see the surgeon," he is only going to send him to the surgeon if there is, you know, an ongoing issue at that very moment. He is not going to comment, "Yes, in five years, you are going to need to see the surgeon." That's where a life care planner comes in.
MR. GREENE: Objection, nonresponsive.
Q (BY MR. GREENE) My question: Based on the records that you have reviewed, has any treating physician said that Mr. Aguilar needs to see an orthopedic spine surgeon more often than the one time that he has already seen one?
A I don't know.
Q Well, based on the medical records that you have reviewed, do you know?
A I am not aware of anyone recommending that recently.
Q So -- okay. Thank you.
What is the basis, then, of your opinion that he needs to see an orthopedic spine surgeon every three years?
MR. McALPINE: Objection. Asked and

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answered.
A Monitoring.
Q (BY MR. GREENE) No, no, not why. I said what is the basis for that opinion?
A My education --
Q What are you basing it on?
A Yeah, yeah. My education, training, and experience.
Q And wound management, we have touched on that earlier?
A Right.
Q Now, why is it medically necessary for him to have an ultrasound of his kidney once a year?
A To monitor any effects of his kidneys from the neurogenic bladder, and that is something that is very commonplace.
Q As a result of the October 11, 2013, incident, what medical records have you seen that require him to have an ultrasound on his kidney once a year?
A He had ultrasounds of his kidney.
Q Right.
A Yeah.
Q Have you seen a recommendation for him to do that every year?
A Like, nobody has said, "Yes, from here on out,

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he is going to need it," but he has been having it so...
Q Right. He has had them on, what, routine visits?
A Yeah.
Q How frequently --
A For neurogenic bladder, not routine. I mean, routine for a spinal cord but...
Q Okay. The X rays on his spine, you are again saying he needs to see -- he needs to have that done every three years. Why is it not acceptable just for him to have one X ray, I mean, on his spine?
A Well, because if you understand the nature of his disease, it's --
Q I'm sorry. Just to be clear, his lumbosacral spine. I'm sorry.
A Right. So now I am assuming he has a lower -- lower extremity paralysis and he is going to be in the wheelchair now, right? So let's just forget about the subsequent accident that happened.
He has a spinal cord injury. He is going to be in the wheelchair. He will develop issues in the low -- low back because he is in a seated position for, you know, extended periods of time. That's not true now because he is actually having a -- he is going to be more in a lying position.

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But the -- in the formation of this life care plan, it's basically monitoring for ongoing and worsening of any disk abnormalities based on his spinal cord injury and based on the fact that he has the ankylosing spondylitis and that it will -- he will have an overall worsening of the spine over time.
Q Okay. So I heard a couple of things.
A Uh-huh.
Q No. 1, because of the ankylosing spondylitis, which is a preexisting condition, right?
A Right, but that's not what I said initially, yeah.
Q I didn't say that's what you said. I said I heard a couple of things.
I also heard that he is not going to be sitting in the wheelchair anymore, because of his current condition, right?
MR. McALPINE: Objection.
Are you -- you are asking her if she can testify about what you heard? That's a vague question. What are you asking?
MR. GREENE: What's your objection? Vague?
MR. McALPINE: My objection is vagueness, yes.

Q (BY MR. GREENE) Ma'am, from your recent testimony, I think you said that Mr. Aguilar will not be sitting in the wheelchair because of his current condition, true?
A Correct. He will be sitting in a wheelchair because I have outlined that for him as well, so any time that you are in an extended seated position for any period of time, especially if you are a tetra- or quadriplegic, you are putting extra stress on the spine and the -- you know, scoliosis is an -- it can be an issue, disk issues, as well as, for him, worsening of the ankylosing spondylitis, because of his -- the posture that he will have to be in.
Q So the X rays of his lumbosacral spine relate to the fact that he is a tetra- or quadriplegic?
A Right.
Q Okay. This incident resulted in paraplegia, though?
A Right, either.
Q So --
A Yeah, yeah. So I would do X rays if he was paraplegic. I would do X rays if he is tetraplegic. It's the same. And it's a monitoring thing to detect scoliosis, to detect if he is having any worsening of that area.

Q Okay. But if he is a paraplegic, it's not necessary?
A Incorrect.
Q Okay. X rays of the thoracic spine, he needed those X rays anyway because of the ankylosing spondylitis, right?
A This is in addition to what he would have needed anyway, because he is going to be having way more films in addi- -- one time every three years, I am saying. So a portion of the X rays he is going to get to monitor are due to the injury. Obviously, he is going to have more X rays than one X ray every three years, if he has ankylosing spondylitis.
Q Okay. I am confused, because if he is going to have it anyway, why are you putting into your life care plan as something new that he needs for the future, as a result of this incident?
A I'm saying a portion of the future is going to be monitoring the area in the thoracic spine that was injured as a result of this accident. So we need to monitor that area that was injured by doing one X ray every three years for the duration so...
Q Okay.
A Monitoring the injury. Yes, he has ankylosing spondylitis. Yes, he will have X rays. I am saying, in

addition to his ankylosing spondylitis X rays, he is going to need additional X rays.
Q The ankylosing spondylitis X rays are of that area -- are of the thoracic spine, right?
A I am just saying over and above those.
Q The X rays for the ankylosing spondylitis are of the thoracic spine, correct?
A They are of the whole --
MR. McALPINE: Objection. Asked and answered.
A -- the whole spine, yes. They include the thoracic spine. I'm just saying that because of his injury, he will need X rays over and above what would normally be required for the ankylosing spondylitis.
Q (BY MR. GREENE) So based on this section of your life care plan, you are requiring him to have treatment that he is already going to have?
A No, no, I am not.
Q Well, he is already having the X rays of the thoracic spine due to the ankylosing spondylitis, correct?
A No. I am saying he is going to need these, in addition to what he is having. He is going to have way more X rays. This is just in addition.
Q And this, the -- okay. But why does he need

it more than one time, or as needed? Why are you --
A He has a spinal cord injury at that level. For monitoring of worsening, for looking at other levels above and below that area, for monitoring of the bone density, for monitoring for scoliosis because of his injuries. So there is plenty of reasons to back up -- in addition to the ankylosing spondylitis, which I am saying is not related to these -- monitoring of the injury.
Q Okay. This assumes that he is going to do it every three years, though, right? Ultimately it's up to him, true?
A He is going to do it way more than every three years. He -- somebody will order an X ray. He will be at the emergency room. Somebody will order it for him. Guaranteed he will have more than three X rays -- or once every three years.
Q But --
A And, again, a life care plan is not based on -- going back, he may not do any of this, but I am not being asked to comment on whether I think Mr. Aguilar is going to follow through with my life care plan. I am -- I am commenting on what I believe, in my opinion, he will need in the future to get him to the highest level of function, lower, you know, his pain and

suffering, and decrease duplications.
Q Right, but my question is: Why is it not sufficient for him to have a thoracic spine X ray once, or as needed, as opposed to you assuming that he is going to be required to have one every three years?
MR. McALPINE: Objection. Calls for speculation, argumentative, asked and answered.
THE WITNESS: Answer?
Q (BY MR. GREENE) Yeah.
MR. McALPINE: Yeah, of course.
A In my opinion, this is the as needed. This is the as needed. In order to put a price on something, I have to put a number on something. I can't just say -- throw a number. It's -- this is as needed.
Q (BY MR. GREENE) Okay. What's the basis of your number?
A Education, training, experience.
Q The neuropsychological evaluation?
A We talked about that.
Q That's what we talked about earlier, correct?
A Right.
Q The venous Doppler studies?
A Monitor for DVTs because of his condition. Let's just say, lower extremity paraplegia, he would be warranted to have that once every two years for the

duration, as a complication of spinal cord injury due to sedentary status.
Q What is a venous Doppler study?
A It's an ultrasound of the leg to look at the veins to look for clots.
THE VIDEOGRAPHER: We have five minutes.
MR. GREENE: We can go off the record. We can take a break now.
THE VIDEOGRAPHER: We are going off the record at 1:32 p.m.
(RECESS FROM 1:32 P.M. TO 1:34 P.M.)
THE VIDEOGRAPHER: We are going back on the record at 1:34 p.m.
Q (BY MR. GREENE) So it's your opinion that the venous Doppler studies are done with every paraplegic?
A It is in my experience that a complication of spinal cord injury is blood clot in the legs because of immobility and not walking, so they are at risk for that. In my opinion, he will need that -- need those studies in the future.
Q And you are recommending every two years?
A Yes.
Q Okay. So in the almost three and a half years since he has sustained this injury, how many venous Doppler studies have been done?

A I don't believe he has had any recently.
Q Well, not just recently. Period.
A I'll check here.
In my report records, I hadn't seen that he had had any, but it doesn't mean that it wouldn't be prudent to include that.
Q Based on the medical records, has he had any problems with clotting in his legs?
A No, not that I have seen, but I am basing it on the fact that he has a spinal cord injury.
Q The bone density study, why are you recommending the bone density study?
A Because spinal-cord-injured patients develop osteopenia just as a result of their injury.
Q Based on the medical records, has any doctor recommended a bone density study since October 11, 2016, and prior to -- excuse me -- October 11, 2013, and prior to October 11, 2013 --
A No.
Q -- '16?
A Not that I have seen, no.
Q So why is the bone density medically necessary, in your opinion?
A Because of his spinal cord injury, because he -- it's likely that he will develop osteoporosis from

the injury itself and that needs to be monitored.
Q In the roughly three and a half years that he has had this injury, the T12 ASIA B, has any doctor made any reference to issues with osteoporosis or bone density?
A No. He probably hasn't developed anything yet. I do think that if you look at any of the PM&R textbooks even, they are going to mention that, you know, this is a common complication of spinal cord injuries so that's why -- my reason for including -- excuse me -- including it.
Q Okay. According to you, the medical literature will say it's a common complication, true?
A Right.
Q It doesn't mean it is going to happen, though, does it?
A It doesn't mean it's not going to happen just because he hasn't had it in the past two years. I mean, he has a long way to go.
Q Right. But there is no indication right now that he is suffering from osteoporosis?
A No, but we need a baseline, first of all, right, of his bone density and then we follow him. And the nature of osteoporosis is it's very gradual and it -- you don't end up having issues until later, so

that's my reasoning for including it.
MR. McALPINE: I couldn't get my objection in. I'm going to object to that as argumentative and assuming facts not in evidence.
Q (BY MR. GREENE) What is "KUB"?
A It's an X ray of the kidney, ureter, bladder. Evaluate for stones.
Q Okay. Wouldn't the ultrasound evaluate for stones?
A Right, both. Ultrasound doesn't always pick up everything. It's also a way to evaluate the abdomen, so you -- it's an abdominal X ray, but you just want it to be so that it will evaluate the whole thing. So it's in addition to the ultrasound.
Q Right. But why -- why is the KUB medically necessary if he is having the kidney ultrasound done?
A Because I don't think that the KUB necessarily would pick up other abdominal issues that he is having, and it's also kind of used as a screening tool. If he is just having, like, vague abdominal pain and we don't know if it's the bladder, they may do one or the other. So I'm saying that it's reasonable to assume that these are screening tools that he will need in the future.
Q In the medical records that you have reviewed, have you seen any indication that a KUB was necessary?

A Not so far, other than the fact that he has a GI bleed from medications so...
Q The medications, you have a muscle relaxant. Which muscle relaxant is this?
A All the medications are outlined in Section 6, so it is... baclofen.
Q Is oxybutynin, is that appropriate?
A That's for the bladder. Oxybutynin is for the bladder. Baclofen is for the muscles. It's a common antispasticity medication.
Q And why have you concluded that he is going to need this muscle relaxant for the rest of his life?
A Because he has a spinal cord injury and he will develop spasticity because of his injury, and that is something that gets worse over time and that's something that's commonly managed with a muscle relaxant.
Q You anticipate that he is going to develop that, right?
A He has already --
Q He has already?
A -- spasticity, yeah.
Q So he is already taking muscle relaxants?
A He is taking -- I don't know if I had the complete list when I -- when I did this, but it is

something that almost all spinal-cord-injured patients need. And then if you will hand me the physician consultation, I can look at all of his medications again.
I don't know if he was taking it when I saw him, but it is something that is used for spasticity and pain in spinal cord injuries.
Q Okay. So based on the medical records, the medication that you are recommending, he isn't taking it now?
A Based on the interview and exam, I don't know if he was taking it at the time that I saw him, as far as the medical records. I don't see that we have a good list of the medical records in -- of the medications in the medical records.
I am basing it on my education, training, and experience that individuals with spinal cord injury use baclofen and usually at much higher doses than what I am recommending. They sometimes even necessitate a baclofen pump, which I haven't actually said that he will need, which he may need, but which I haven't included.
Q Well, we have agreed a couple of times that a life care plan is supposed to be individualized, right?
A Right. And that it has to be more likely than

not that he will need it, so that -- you know, if I haven't included something, it's because -- or if I haven't discounted something, that's why.
Q With respect to Mr. Aguilar, you don't see any indication that he is using that medication?
A I don't know if he is. I don't know if he is or isn't. I really would like to, you know, get the current medical records and see medications, because I have a hard time believing that he isn't on some sort of muscle relaxant.
Q Well, looking at your medical records review, which is Exhibit 2, and the medical records you relied on in formulating your opinions, back on December 1st, 2016, was there any indication in any of those medical records that you have already reviewed that he is taking that medication?
A Not as of this report, no.
Q What about as of this medical records review?
A If I can see that, please.
The only mention was 2014 of any medications. And they do not have a complete list, but they do have blood pressure and pain medication. I don't see that they have the baclofen.
Q Do you see that they have any other medication for the muscle --

A I don't have a complete list in any of the records so I don't -- I would like to get a complete list of what he is taking, obviously.
Q Well, based on the records that you have, do you see any other reference to a muscle relaxant?
A No, not -- not after that accident.
Q And the analgesic, why 12 times per year?
A So basically that's how we price out medication. So as far as specific analgesic for him, it was throughout the records that he was needing an analgesic for his pain, even before the October, 2016, accident.
The specific one that I outline is kind of a little bit not as strong analgesic as what he is taking because, you know, there is complications associated with taking narcotics like Norco. So I have put him on, in this plan, a -- recommended a lesser opiate, tramadol, which is going to help deal with the pain associated with his deformities and his spinal cord injury.
Q With all the medications that you are recommending, with respect to your opinions, the duration is going to change on all of them, right?
A Anything that's 19 will likely go down.
Q What about anything that's ten?

A Which one are you --
Q Does that also go down?
A There is nothing that's ten.
Q Flu vac- -- wait a minute. Hold on. I'm sorry.
What about five, erectile dysfunction, is that going to go down?
A No, I don't think so.
Q The orthopedic spine surgeon, that's a duration of ten. Is that going to go down?
A I am only anticipating currently. Obviously, I don't know what my final report is going to say, but right now, currently, I am only going to decrease anything that's 19.
Q But that, too, could change, potentially?
A It may be -- it may be -- you know, I might decrease it more than 10 percent. I don't know yet but --
Q Well, I'm sorry. No, no.
A Yeah.
Q When you said -- bad question.
You said you are only anticipating decreasing everything that's 19.
A Right now, yes, yes.
Q So none of the other numbers are going to

decrease by 10 percent --
A I mean, again, I haven't really had time to --
Q -- for duration?
A -- kind of go through everything. It's just been since yesterday. Potentially I may decrease a few of the things. I just don't know yet so...
Q Okay. All right. So we'll continue to go through this, but the fact of the matter is, without knowing the duration, you really don't -- your opinions aren't complete right now?
A That's correct, because I did express to you that I was going to change the duration of his -- of the life expectancy.
Q And so the opinions that you are expressing in this report that's dated December 1, 2016, as we are sitting here today in your deposition, based on new information that you have learned, these opinions in Exhibit 11 are incorrect with respect to --
MR. McALPINE: Objection. Argumentative, too general.
Q (BY MR. GREENE) -- with respect to the duration and how the duration affects future cost?
A All I am going to say was in the original report in December, I did reserve the right to amend my report, which I have not been asked to do so. I am

expressing to you that I do have changes that I would like to make.
I am not outlining specifically each one, because I don't feel like I have had adequate time and, you know, I am not going to do it on the fly, because I take this very seriously.
So I would like to opportunity to make those changes and put adequate thought into it and go about my normal methodology in doing so. I expect that all the 19 durations will decrease. I am not sure about the other ones.
Q Okay. The -- is that the flu vaccine --
A Yes.
Q -- Pneumovax?
What are the CBC recommendations with respect to Pneumovax?
A Every five years over 65, especially those with other, you know, lung -- lung diseases. I know that spinal cord injury, they -- they need it. This isn't just like a soft recommendation, like, "You should get it if you are over 65 and healthy." It's, like, "You need to have it because pneumonia is a significant complication that can kill you."
Q It's every five years, and you are recommending it every two years?

A No. That's actually a typo. That should be every five years.
Q So this flu vaccine --
A It should be 0.2, instead of 0.5.
Q Okay. And he has already had the flu vaccine this year, right?
A I don't -- I would assume so. I don't know. Yeah, so you could take one of the flu off if he's had it this year, if he has also had the Pneumovax. I didn't have that information at the time I did that report -- did this report.
So if he had the Pneumovax, you know, in the last five years, great. We can take -- we can start -- start it at age, you know, 70, or whenever he had the last one. So those can potentially be decreased, you know, somewhat, if he has had them and he is up to speed on those.
Q And I'm sorry. I said the "flu vaccine" and "Pneumovax" and I kind of -- kind of combined those, but you had them listed separately in your report.
A The flu vaccine is for influenza and that's recommended for the general population every year, especially the old and the young, or chronically ill.
The Pneumovax is a pneumonia vaccine, so that's different. So that's recommended for over 65 and

chronically ill as well.
Q Okay. So if he had never had this accident on October 11, 2013, he was going to be required to take the flu vaccine anyway.
A Maybe. I mean, I don't know if he -- I am saying that I don't know for sure if he would have gotten it. I am recommending that he absolutely needs to get it, because of the spinal cord injury. That's all I'm saying, because --
Q Right.
A -- of the pneumonia complication that can occur with spinal cord injury.
Q Okay. Let me back up. You said it's recommended for everybody anyway, correct, the flu vaccine?
A Yes.
Q All right. So whether he would have had this accident on October 11, 2013, or not, he was still going to be required or recommended -- it was still going to be recommended that he have the flu vaccine, true?
A Correct.
Q So that's something that's already within his general healthcare, right --
A It should be.
Q -- as a recommendation?

A It should be. I am just saying that specific to his -- I mean, I understand what you are saying, but specific to his spinal cord injury, he absolutely needs it now. There is no question. It's not a soft recommendation.
It is because he has a spinal cord injury, you are absolutely getting it on your yearly checkup. There is no questions asked. You are at increased risk.
Q But that's the case anyway, though. He's -- he should be getting it anyway is my point.
MR. McALPINE: Objection. Argumentative, mischaracterizes prior testimony.
A I am -- by including it, I am placing utmost importance on the fact that he get it.
Q (BY MR. GREENE) By including it, you are also charging for something that he should be getting anyway, regardless of if he had this accident or not?
MR. McALPINE: Objection. Argumentative, misstate --
A I don't know that -- no.
MR. McALPINE: Objection. Argumentative.
A I don't know that that's true, because you can have a 70-year-old person. What if they -- you know, they have to pay out-of-pocket for things. Hopefully they don't have to pay for that. We didn't get into any

of the cost aspects. You know, I don't know that he will get it. I don't know that, but I am recommending that he get it.
Q No, no. I understand what you are recommending.
A I don't know that he would get it otherwise.
Q Right. And I understand that you are recommending it.
A Yeah.
Q And I guess that's where we are. My point is: It was already going to be recommended that he get the flu vaccine, whether he had this accident or not, true?
MR. McALPINE: Objection. Argumentative, asked and answered --
A Yes, because everyone --
MR. McALPINE: -- assumes facts not in evidence.
A -- is recommended to have it.
THE REPORTER: I'm sorry. Can you repeat your objection?
MR. McALPINE: Yeah. Objection. Argumentative, assumes facts not in evidence, asked and answered.
A I am recommending it because I am placing more importance on just -- he is just a general person. I am

saying he absolutely needs it. I don't know that he would get it if he didn't have this.
Q (BY MR. GREENE) All right. But you don't know if he is going to get it simply because you recommend it, though, true?
A No, that's true, but I am saying in this view of him, looking at his spinal cord injury, he needs a flu vaccine and he needs a pneumonia vaccine. So, I mean, I think you can kind of take a guess if he would have gotten it or if somebody would have recommended. I don't know that anyone would have recommended it. I don't know that.
Q Well --
A I don't know if he would have gone to a primary that gave him the flu vaccine.
Q Ma'am.
A I am saying I am being asked -- it would be -- it would not be prudent of me to not include it as a PM&R doctor with a spinal-cord-injured patient.
Q I understand that. But as a man 65 years of age, his doctor would recom- -- every doctor recommends that a person 65 years old takes the flu vaccine, true?
A I don't -- I don't know what every doctor does.
Q Okay. The CDC recommends that you take the

flu vaccine, and Mr. Aguilar would be included in that recommendation, true?
A That's true, yeah.
Q All right. I'm skipping to page -- what are we talking -- "Physical Therapy, Periodic." Why are you recommending therapy once a month?
A I am actually recommending 12 times per year. Where do you see once a month?
Q You are right. I am just assuming it was once a month.
A No, sorry. So --
Q But you are right.
A So basically this is actually 12 times per year, assuming he will get it in short bursts. It might be six and six.
Q Okay.
A It's probably not going to be once a week, although for kind of -- for patients like him, there is kind of a preventative PT that they will go through, but that's not what I have outlined. But it's just -- I am assuming he will get it in bursts, because he will have ups and downs related to his injury.
Q Well, shouldn't it be recommended annually, the PT? Annual PT --
A Once a year?

Q Let me -- you have got to let me finish.
Annual PT and three sessions per year to help update his home exercise program, wouldn't that be the more prudent approach?
MR. McALPINE: Objection. No foundation.
A Again, I had done this report back in December. I may change it to home exercise -- or to a home PT program, but I am not sure yet. At the point that I had -- because I think it's going to be very cumbersome for him to go out of the house. I don't think it was as cumbersome at the time of his initial injury.
So that may be something that actually changes so that it will be home health PT, but I don't -- I don't -- again, without a supplemental report -- but my thinking in doing it at the time that I did it was that with his spinal cord injury, he will need kind of preventative or PT that -- after kind of a worsening of his spinal cord injury.
Q Right. But we are only talking about the care before October 4th, 2016, before that subsequent injury.
A Right. And I --
Q Before that subsequent injury, he would have required annual PT with three sessions per year --
A No.

Q -- to update the home exercise program?
A No. I think I would recommend outpatient. If it was just talking about the paraplegia, outpatient for him.
Q Okay. Well, let's make sure --
A Which is what I recommended again.
Q -- that's all we are talking about in this life care plan, right, paraplegia?
A Right.
Q Okay.
A But I have to be realistic, too, so I would probably -- because he is not -- let's be realistic. He is not going to get to go to outpatient. He is not going to get that. He is going to get home health now.
So based on his comorbidities, which is the tetraplegia, which is now he can't really do much at all, I think we would have to go to a PT home health.
Does that make sense?
Q Is that --
A Which is --
Q How would that affect this opinion?
A I don't have that price, so it's going to change it to be a different entity. We are going to price out a home health visit.
Q Is it going to be more or less?

A I don't know. It will likely be less.
Q Right, but what I am hearing you say now is that's going to happen not because of the paraplegia from the October 11, 2013, incident but because of the subsequent incident in October, 2016. That's why you are doing that, true?
A I mean, I can generally say that it's probably going to be less because of his tetraplegia, because outpatient therapy is way more involved than a home health person coming in three or four times a year. Normally, I do four times per year.
So I think, because of his comorbidities, it will go down, but I just -- you know, since I haven't done the subsequent report, I actually hadn't thought about that specific piece. I've only thought about the life expectancy so...
Q At the time you wrote this report in December of 2016, as a T12 AISA B, was he having physical therapy at that time?
A He had had it. I don't know if he was having it at that very moment. The last record that I had was -- you know, at the time I did this report was March --
Q Okay.
A -- of 2016, so I don't see that he had had it

very recently before that.
Q Between March, 2016, and October, 2016, had he had it?
A No, not from the records that I have.
Q All right. So he hadn't gone to physical therapy at all?
A No, that's fine. I mean, it doesn't mean that I am not going to recommend it, because, again, going back to the objectives of the life care plan.
Q And the basis of the 12 visits over the course of a year is what?
A So the normal kind of stint of physical therapy is two or three times per week for four to six weeks. So if you say two times -- two times per week for six weeks, that gets you to 12. If you do two times per week -- or three times per week for four weeks, 12. So that's the normal subscript- -- prescription of physical therapy, so that's the reason for including it there.
Q Well, let's -- let's individualize this to Mr. Aguilar. What would the physical therapy be for him, not for --
A This --
Q -- the normal person who -- what you normally prescribe?

A This is what I think is going to be adequate for Mr. Aguilar.
Q And so if anyone else opines that it should be one -- it should be annually, with three sessions per year, you disagree with that?
A I have my own opinion, and they can have their own opinion so --
Q Well, no.
A And, again --
Q I am asking --
A Again, you know, I don't know that this is my final recommendation of therapy, now that I have seen more records and seen him in person, so -- but at this time, that was my opinion and if somebody else wants to have another opinion, that's fine.
Q Right. But if they have that opinion, do you have any problems with it?
A I would disagree with it because I am having, you know, to meet the objectives of my life care plan. I am not doing bare minimum.
Q Well, so you are only disagreeing with it -- let me back up.
From a clinical perspective, why would you disagree with it?
A I think that it's very -- I think that's the

bare minimum amount. I don't think three times a year is enough. I think, minimum, four times a year. I think that is the bare minimum for somebody -- and then if you are going to say, "Oh, I want them to get to their highest level of function," highest level of function, you need them to have active, ongoing therapy. You need them to have preventative kind of maintenance therapy, not just, "Oh, let's wait for him to get bad and then we will perk" -- "we will boost him up a little and wait for him to get bad and boost him up and do the bare minimum and, okay, now he gets a little therapy because he has a wound," or whatever.
I'm trying to impress upon the reader that this is something that would help him to get to the highest level of function and highest quality of life.
Q From October 11th through -- October 11, 2013, until October 4th, 2016, was he involved in any ongoing physical therapy?
A I don't have evidence of that in the records, however, it doesn't -- just the fact -- just because of the fact he didn't get it, it doesn't mean he didn't need it or he wouldn't have been better off for it. So, I mean, I have people I do life care plans for and there is -- they don't even -- they haven't gotten any treatment at all in the past two years. It doesn't mean

that they didn't need something.
So I am just looking at him and I do look at the past records and I do take that into account. But just because they haven't had them, because you have been asking me the same question about that, just because they haven't had it at all doesn't mean that they didn't need it or doesn't mean they can't benefit from it.
MR. GREENE: Objection, nonresponsive.
Q (BY MR. GREENE) Based on the records that you have reviewed from October 11, 2013, until October 4th, 2016, was he participating in an ongoing physical therapy program?
A No, not that I saw from the records I reviewed.
Q Occupational therapy. We talked about this earlier and what you told me was physical therapy is for the lower extremities, occupational therapy is for the upper extremities, right?
A Basically, yes.
Q Yes, very basically. But if he is a T12 ASIA B, he doesn't have any problem with his arms, right?
A No, but he is using his arms, right? Overuse of the arms. He is at risk for overuse. He is -- so he could develop biceps tendonitis, which is very common,

as well as OT helps you with ADLs. So any equipment, any reachers, any sock -- helping to put your socks on, equipment for those types of things with dressing, they help you with that. So that's my thinking there.
Q From October 11, 2013, until October 4th, 2016, did you see any indication that he was having problems with his upper extremities?
A No.
Q Did you see any indication that he had developed biceps tendonitis?
A No, not at that time.
Q And the folks who -- whose records you are reviewing, you made a comment earlier that it's the treating physician who sees him for 15 minutes, but, in fact, the treating physician is seeing him 15 minutes a few times a year, over a few years, right?
A Correct.
Q Yes?
A Right. I don't -- I am not going to comment on how often everyone sees him, but, yeah, they don't see -- my point is they don't look at the whole picture of Mr. Aguilar every time they see him. They see him for short, you know, snippets.
Q Right. How long did your exam with Mr. Aguilar last?

A About one and a half to two hours.
Q Okay. So we'll give you the high end, two hours.
A Okay. In addition to, you know, however long I told you before, about six hours of reviewing all the records and --
Q Well, no, no. All right. Sorry. Sorry to cut you off. I apologize. No, no, I am talking about your actual visit with him.
A Two hours.
Q Two hours.
That was the first time you ever saw him?
A Right.
Q Last time you ever saw him?
A Right.
Q You are not treating him on a regular basis, are you?
A No, no.
Q As a physician, would you rely on the person who is treating him regularly or someone who saw him once for two hours?
MR. McALPINE: Objection. Calls for speculation, complete hypothetical, no foundation.
A As far as the treating physicians? I think it would be helpful to ask them what they think about the

future. I don't think they are trained life care planners in the -- for the most part, so I don't think that they -- usually, when I do have the conversations with the treating, they are, like, "Oh, well, you are the life care planner." You know, you can -- that's your department kind of a thing. So they will tell me what they usually do, and then I will kind of project it out. So I don't know how to answer the question.
Q Well, the treating physician took the same oath that you took, right?
A I am not treating Mr. Aguilar in this case but --
Q Right.
A -- yes, we have all taken the oath.
Q Okay. So they have the same interest in -- that you have in helping him to get better, true?
A Right. And they are doing their job, and I have no comment on that at all. I am just saying that the life care plan is a bit of a different perspective.
Q Are there any records that you have reviewed that support the need for occupational therapy, prior to October 4th, 2016?
A Yes. I mean, he stayed at TIRR. He had ongoing therapy when he was at TIRR. He --
Q Occupational therapy, I'm sorry?

A Yeah. He had PT, OT, and speech when he was admitted. That's what -- anyone who is admitted to acute rehab at TIRR, or any other acute rehab, they are on PT, OT, and speech, at least for an eval, and then PT and OT. And then as needed, they will kind of taper off whatever they don't need. But that's kind of the requirements of being in acute rehab.

Q When did he stop with the OT?

A I don't know the exact date of that.

Q Well, you have the records here, right?

A He would have stopped on discharge. If he had any subsequent visits -- he did have the vehicle modification done, so that involves OT. June, 2015, OT re-eval. According to this plan, that's the last that I had.

Q I'm sorry. When was it?

A October 20 -- I'm sorry. June, 2015. June, 2015.

Q And he hasn't attended any other occupational therapy sessions?

A Not at this time. I didn't have evidence of that.

Q And based on the records you reviewed, there have been no complaints or diagnoses of problems with his upper extremities, prior to October 11 --

October 4th, 2016?

A No, but I am assuming that he will have some of the common things that spinal-cord-injured patients have and need to be evaluated for.

Q You also have a nutritional counselor. You have recommended a nutritional counselor. Earlier you told me you don't know if he has gained weight, lost weight. You don't know one way or the other, right? Correct?

A I don't know. Yeah, I don't know.

Q So why are you recommending a nutritional counselor?

A Just for general nutrition, because the spinal -- because of his spinal cord injury. So it is a state that it is -- it can be more of a catabolic state. He was definitely in a breakdown state, and you are using kind of more energy. And just to maximize his potential, I believe that he could benefit from some nutritional input. It's not for weight loss or anything like that.

Q What do the records show with respect to his need for a nutritional counselor? The medical records.

A He -- he likely had it in the hospital, and I didn't see anything after that.

Q When was he released from the hospital?

A He had it done in February, 2014. There was an assessment done, nutritional assessment done, and I don't see that he had one after that.

Q And when you interviewed him, is there anything in your physician consultation that lets you know that he needs nutritional -- excuse me -- that he needed a nutritional counselor before October 11, 2000- -- excuse me -- October 4th, 2016?

A Yes. I mean, just the fact that he has a spinal cord injury. That's all I'm basing it on. It's not --

Q Okay.

A It's, like, let's get him on the right track so that he can maximum the rest of his life, so he knows what to eat, so he knows to eat enough protein and, you know, it's just basically related to the injury.

Q So from October --

A Whether or not there is weight-loss needs or something else, I mean, I'm not addressing that.

Q From October 11, 2013, until October 4th, 2016, he did not have a nutritional counselor, right?

A Just --

Q Correct?

A -- after the injury.

Q Other than --

A Yeah.

Q -- being in the hospital?

A No, not outpatient, I don't believe he had.

Q And he is --

THE REPORTER: I'm sorry.

(OFF-THE-RECORD DISCUSSION.)

Q (BY MR. GREENE) And since his release from the hospital, there has been no indication that he wants a nutritional counselor?

A I don't --

MR. McALPINE: Objection. Compound.

A I don't see that he has had one. I don't know what his wants are, as far as wanting one. I believe that it is -- that it could improve his quality of life if he gets a nutritional evaluation.

Q (BY MR. GREENE) Based on Mr. Aguilar, other than -- well, based on Mr. Aguilar and his condition after October 11, 2013, prior to October 4, 2016, what is it about his condition that leads you to conclude that he needs a nutritional counselor?

A The fact that he has a spinal cord injury, period.

Q That's it?

A Yeah.

Q So every person with a spinal cord injury

needs a nutritional counselor?
A At least in the beginning, yeah.
Q Okay.
A To get -- to get them on the right track, I think that that is helpful for quality of life the rest of his life.
Q Okay. He had a nutritional counselor in the beginning until --
A Yeah. Everybody has one in the hospital. Sorry.
Q Okay. He had one in the beginning, in the hospital, true?
A Yes.
Q So is it your opinion that every person who has a spinal cord injury, once they are released from the hospital, they require a nutritional counselor?
A I believe that they can benefit from a nutritional evaluation and counseling.
Q My question was: Do they need one? Is it your opinion that they need a nutrition -- that they need a nutritional --
A Yes.
Q -- counselor?
A Yes. To meet the objectives of the life care plan, yes.

Q Well, so now you went back to the life care plan with Mr. Aguilar.
A And that's what I --
Q I'm talking --
A And that is what I have been asked to do. You are not -- I am not here to answer questions about what people normally do, you know, at the bare minimum. It's like -- I am asked -- I am here today to answer questions on, "You are the life care planner. What do you think that he is going to need and" -- "to get him to the highest level of foundation?" That -- I am answering it within that paradigm.
Q No. Actually, you are here to answer the questions that I ask that are related to this case.
You just stated that every person who is a -- has a spinal cord injury needs a nutritional counselor. That was your earlier testimony.
My question to you, because you went back to Mr. Aguilar and the life care plan, outside of this life care plan, is it your opinion that every person who suffers a spinal cord injury needs a nutritional counselor after they are released from the hospital?
MR. McALPINE: Objection. Argumentative, outside scope of direct, assumes facts not in evidence, object to sidebar.

Go ahead.
A I believe he can benefit from nutritional counseling because of his spinal cord injury.
Q (BY MR. GREENE) Okay. Again, my question was not limited to Mr. Aguilar. My question was based on your earlier testimony that every person who has a spinal cord injury needs a nutritional counselor once they are released from the hospital. Is that your opinion?
A I don't think everyone needs it. I think that Mr. Aguilar can benefit from it.
Q Okay. The next cost, as far as service items, is the electrical hospital bed. Now, a person who is a T12, they -- it's not recommended that they have an electrical hospital bed, is it?
A Again, we are back to decreasing complications. I think that he needs a hospital bed so that he can prevent wounds.
Q Okay. He has not had a hospital bed for the last three years, other than when he was in the hospital, true?
A I don't know that.
Q Well, you interviewed him, right? You didn't ask that question?
A Yes. I don't -- let me check.

Q Isn't there a section in there about what devices he has?
A I don't have that information.
Q So sitting here today, you don't know if he has a hospital bed or not, true?
A True.
Q Can I see that?
A (Witness tendering to Counsel.)
Q Well, a person who is a T12, you want them to use their upper extremities, though, true?
A They have -- yeah, they have to use their upper extremities.
Q And an electrical hospital bed would limit his use of his upper extremities somewhat; isn't that fair?
A No. Why would it limit it?
Q Well, he is not using his arms to get up out of bed. He is using the electrical bed.
A It's not to help him with getting up. It's just the fact that he has a movable -- to kind of help with adjusting with offloading and things like that and that he has an adequate mattress and an adequate, you know, setup to prevent complications. This is not about him, like, helping him to get up and...
Q So is it fair that it's your opinion that a hospital bed is required for a person who is a T12?

A I think that it, again, will prevent complications and get him to the highest level of function.
Q Is it required?
A I'm -- I don't think that that's a relevant question, sorry. I think that -- I believe that he will need it and that it will get him to the highest level of function.
Q Is it required, ma'am?
A He doesn't have to even have a house over his head. I mean, what -- I don't know where you are going with the question. It's like -- he doesn't need any of it, and he will do poorly. Like -- but if he gets a lot of this stuff, he will do well, but, you know, in spite of his condition. So it's...
MR. GREENE: Objection, nonresponsive.
A He doesn't need medications either. He can just have all these complications happen to him. I mean, it's -- I am being asked to comment on what his -- what is the -- you know, what are the things that he needs to get into the highest level of function to prevent complications. It is not unreasonable that a person with a paraplegia would need a hospital bed.
MR. GREENE: Well, objection, nonresponsive.

Q (BY MR. GREENE) I'm not asking you if it's unreasonable. My question was: Is it required for Mr. Aguilar to have an electrical hospital bed?
A Yes.
Q Why?
A To prevent complications.
Q What complications?
A Wounds, contractures --
Q Okay. Well, as far as --
A -- falls. I mean --
Q As far as we know, he does not have a hospital bed now, right?
A I don't know that.
Q You don't know that?
A I don't know if he does or doesn't.
Q Let's just -- assume with me --
A He was in a hospital bed when I saw him, but I don't know if he has one at home.
Q Where did you see him at?
A In a rehab facility.
Q Okay. And the rehab facilities typically have hospital beds, right?
A Correct.
Q Okay. When he was living at home with his daughter, have you inquired about whether he had a

hospital bed?
A I don't recall if I asked him that question.
Q A power wheelchair. With respect to Mr. Aguilar and his paraplegia, he is not required to have a power wheelchair, is he?
A I think for long distances and I think that it's -- it is reasonable that he will have a power wheelchair, yes.
Q Okay. Well, you do --
A And I made that conclusion before I even saw him and saw how debilitated he was but...
Q Well, he is debilitated now, ma'am, because of a subsequent accident, right?
A I am aware of that.
Q Okay.
MR. McALPINE: Objection.
A I'm saying I made the conclusion before I had any details about that.
Q (BY MR. GREENE) Right. You just made that conclusion without interviewing him, without examining him. It's just a conclusion that you made?
MR. McALPINE: Objection. Argumentative, asked and answered.
Q (BY MR. GREENE) Right?
MR. McALPINE: Objection. Argumentative,

asked and answered.
A I believe that based on his paraplegia, he will need an electric wheelchair.
Q (BY MR. GREENE) Well, you are aware, though, that prior to that October, 2016, accident, he did not have an electric wheelchair?
A I don't know that.
Q You don't know that?
A No.
Q If he did not have an electric --
A He had a -- he had a vehicle that was hand-controlled so...
Q If he did not have an electric wheelchair, would that be a surprise to you since --
A No, I am not surprised. People don't get the things that they need, so I am not surprised.
Q Well, do you know if he needed one back then?
A I think that there are definitely cases of paraplegia where they could benefit from having -- especially for long distances, benefit from having an electric chair.
Q Let me tell you what: Since they were not nice enough to give you his deposition, let me refer you to his deposition testimony.
MR. McALPINE: Objection. Sidebar.

Q (BY MR. GREENE) Reading from Page 75, answer, Line 14: "Because originally from my waist down, I didn't have any mobility at all. After that, I went home and I had -- oops. Always -- I could always feel if they touched my legs or my feet. I have never lost that. Mobility, yes. And then when I was sent -- Dr. Prasarn sent or told us, my daughter Tiffany and me, that we needed to find a nursing home so that I could go back -- go lie on my back for 30 days to help promote the healing" [sic].

"So gradually over the last two and a half, or however long it's been, years, I have gained some mobility in my legs. My feet are still paralyzed. I can still feel touch, but I can't move my -- wiggle my toes and I can't move my foot at all, both of them. I was progressing, you know. I was progressed, but about as far as I could go on with them" [sic].

Did you know that Mr. Aguilar felt that he had progressed prior to that October 11th -- October 4th --

A Can I --

Q -- 2016, incident?

A Can I see my physician consult, please? Or I can actually look at this.

He said he was at the wheelchair level after the accident.

Q What does that mean, "at the wheelchair level"?

A Meaning he -- he is not ambulating anymore. He needs a wheelchair. I'm sorry. Can I see that one, too?

And then as far as if he thought he progressed, I was actually surprised at how positive the guy was, but he... I think he thought he was doing pretty well, I mean, as far as, like, he -- he used the wheelchair, he could get around in the car with the hand controls. I think he probably thought he had progressed, if that's what you are asking.

Q Reading from Page 84, Line 20, "If it's not raining, are you able to get around and go where you need to go?"

"Pretty much. Now, I still have back pain so -- because of the fact that I have to load the chair into my car by myself and it's heavy -- I have to manually pick it up. If my back is not feeling -- if it's sensitive that day, I can't -- I can't drive and I can't -- because I can't put the chair in the car" [sic].

"You had back pain before this accident happened?"

"Yes, sir."

So does that tell you whether he had an electric or a manual wheelchair, based on his testimony?

A Not specifically. I would probably guess manual, because he can't -- he didn't have a -- like one where he just drove in and transferred himself from the back to the front or could drive the wheelchair in.

Q And as a paraplegic, would you want him using a manual wheelchair or an electric wheelchair, if he could use the manual wheelchair?

A I think that I would, for him specifically, I would opt for the electric. If he was just, you know, paraplegic, age 40, like, go manual because you are going to want to make sure that they are exercising and they can exercise. I don't think that the manual is ideal for him.

Q Now, you are not complaining about the doctor who prescribed a manual wheelchair, are you?

A No.

Q And as far as you know, based on Mr. Aguilar's testimony, he used the manual wheelchair, he was able to get around, and he was actually pretty proud of the fact that he was able to drive and do things on his own, right?

A Right.

Q And the manual wheelchair allowed him to do

that, true?

A Right, and I don't believe he will -- you know, if he wouldn't have had this other accident, let's just talk about if nothing else would have happened, I don't believe he would have been at that level for that long, let me just say that, because he does have the comorbidities that he has. He is older. I think the fact that he was at that level is probably the highest level that he would have been at.

Q Right, but you don't -- based on Mr. Aguilar alone and the records that you have seen, you don't have any basis for that in those medical records, do you? For that opinion that you don't think he would have been at that level for long, what are you basing --

MR. McALPINE: Objection.

Q (BY MR. GREENE) -- that on?

A That's not based on --

MR. McALPINE: Objection. Vagueness and argumentative.

A That's not based on the medical records. That's based on experience with older individuals with spinal cord injury and significant comorbidities. It's not likely that it's going to be really long-term that he can just keep hauling the wheelchair in and out. I mean, it's not likely.

Q (BY MR. GREENE) Right. But individualizing it to Mr. Aguilar, there are no records that support that -- that statement, are there?
A No. It's my opinion. It's my opinion that I don't believe that he could have gone on like that for, you know, more than five years. Five maximum, you know.
Q And because you have recommended the power wheelchair, you are also recommending the power wheelchair battery, right?
A Correct.
Q If another life care planner comes along and says the power wheelchair is not necessarily, not medically necessary, are you going to argue with that?
A If I am recommending the wheelchair, I am going to include the battery and the maintenance.
Q Yeah. No, no, I'm sorry. I apologize.
The power wheelchair, period, if someone says or opines or concludes that the power wheelchair is not necessary, medically, for a person in Mr. Aguilar's condition as a T12 AISA B, would you disagree with that?
A They can have that opinion, and I can have my opinion. So I don't agree with that, no.
Q A urine bag. You are recommending a urine bag twice a year. Now, why are you recommending the urine bag?

A It's for catheter, like, so -- to collect the urine.
Q Well, if Mr. Aguilar testified that he always used his catheter, always catheterized himself, does he still need a urine bag?
A Okay. I had to be realistic when I'm doing the plan. I know he can't self-cath anymore so...
Q Well, you didn't know --
A Yeah, yeah, I did.
Q Hold on, hold on.
A No, no. I knew the accident. I knew the accident had occurred.
Q What accident?
A The second one.
Q Right. But -- okay. Thank you for that.
This urine bag is related to the second accident then, right?
A No.
MR. McALPINE: Object to --
Q (BY MR. GREENE) Oh, he can't do it anymore because of the second accident?
A Right, but --
Q All right.
A Right, right, right. Let me say one thing: I recommended a suprapubic catheter for him. He cannot

self-cath anymore if he has a suprapubic catheter. I am recommending a suprapubic catheter because he has neurogenic bladder and because of the complications associated with self-cathing and with neurogenic bladder. With the suprapubic cath, he needs this bag, not to mention the fact that he can't self-cath anymore anyway so...
Q Prior to the October 4, 2016, accident, was he using a urine bag?
A No. He was self-cathing --
Q All right.
A -- and he was having complications.
MR. GREENE: Objection, nonresponsive.
Q (BY MR. GREENE) Prior to the October 4, 2016, accident, was he using a urine bag?
A No.
Q Okay. Prior to October 4th, 2016, he was also not using a suprapubic catheter, was he?
A No.
Q Prior to October 4th, 2016, was the suprapubic catheter nec- -- medically necessary?
A I believe that he would have ended up getting a suprapubic catheter, and I believe that it would have benefited him, the fact -- I don't know -- you know, if you want to say, "medically necessary or not," you can

get any doctor to say something is medically necessary. It's very common that patients with spinal cord injuries end up with a suprapubic cath. It's way less complication. They don't have to self-cath, less infection, all that, all that.
Q Prior to October 4, 2016, was there any indication in any medical record that Mr. Aguilar was going to need a suprapubic catheter?
A No.
MR. McALPINE: Object to the --
Q (BY MR. GREENE) And why are you recommending the recliner?
MR. McALPINE: -- form of the last question. Object to vagueness.
A What?
Q (BY MR. GREENE) Why are you recommending the recliner?
A He can't -- with the paraplegia, he can't sit in a normal chair, because of the decreased balance and the muscles that it would take him. So it's just as a quality-of-life issue for him so that he can sit somewhere other than bed or the chair.
Q Did he have a recliner before December 1st, 2016?
A I don't know that.

Q Had he requested a recliner before December 1st, 2016?
A I don't know.
Q So the basis of your recommendation that he use a recliner is a quality-of-life issue; is that fair?
A It's a highest quality of life, prevent complication, improve function, yes.
Q What -- what's his current bladder status?
A He was awaiting a suprapubic cath, I believe, when I saw him. He is incontinent, and he still has neurogenic bladder. He doesn't have any control. He -- he is actually -- he was actually -- he probably has a suprapubic cath now, but he was actually scheduled for pre-op, he said to me, a week after I saw him so...
Q And what was his bladder status before October 4, 2016?
A Self-cathing, but still had neurogenic bladder and ongoing skin issues.
Q Now, why are you recommending that he use a shower wheelchair as a -- well, let me back up a little bit.
Are you recommending that he use a shower wheelchair due to the diagnosis of T12 ASIA B?
A Yes.
Q Why?

A I think it's unstable for him to use a shower chair, and I think it's -- and he is unable to stand, and I think that he needs the ability to not have to transfer from a wheelchair onto a shower chair, because of the safety issue. I think this is the safest -- safest option for him is to have a chair he can get into, wheel in, shower, wheel out.
Q Were you aware that he was using a shower chair at the time of his deposition in September, 2016?
A That's fine. I am glad he was using a shower chair. I am saying that I think it would be more optimal if he could use a shower wheelchair. And I have only recommended that one time, over the course of his life, for $34.91.
Q I'm sorry. Maybe I am looking at the wrong thing.
A We might have different numbers, because of the economic report.
Q Because I have a shower wheelchair, $708.77.
A Shower wheelchair -- oh, I'm sorry. I was looking at shower chair. Shower wheelchair, 708.77.
Q Right. So even though he has a shower chair, you have also recommended another shower chair, too, right?
A Right.

Q So you just said -- you just testified that you don't -- you wouldn't recommend a shower chair. You would recommend a shower wheelchair, correct?
A Right.
Q So why are you charging for a shower chair, as well as a wheelchair?
A Well, obviously depending on his function, I think it's safest for him to use the wheelchair. If he -- I don't remember if I knew he had a shower chair at that time but -- at the time of doing this report, I don't know if I knew that or not. I think, as of right now, I would get rid of the shower chair --
Q Right.
A -- all together so...
Q I understand that.
A Yeah.
Q But as of December 1, 2016 --
A I think I --
Q -- your life care plan charged for both of them. Why is that?
A Because I think at the time -- I am not 100 percent sure, because I don't remember, but whenever I do that, I will give them the option of using one or the other, because he was pretty functional after that first accident, so kind of giving him the option. On a bad

day, he could use one. But for his condition now, I stand by what I said as far as he should not be in a shower chair so...
Q Yeah. His condition now --
A I have to take that into account.
Q Well, your -- you told me at the beginning you were retained to come up with a life care plan based on the injuries he had sustained as a result of the October 11, 2013, accident, right?
A Right.
Q So his condition now should only be taken into account with respect to his life expectancy, right?
A Life expectancy?
Q Yes. You told me earlier it affects his life expectancy, his current condition.
A Right. The subsequent injury, yes.
Q Yeah. Okay. So the costs in this life care plan that you are saying are based on his condition now, those costs should not be in here.
A And I let you know before, I am going -- would like to do a supplemental report. I am saying the thought process that I had when I included it was the fact that he had a paraplegia. He was going to have good days, bad days. He should have access to both, one time each. Right? I am not saying he needs five of

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them over the rest of his life.
I am saying that he was -- you know, I don't know if I knew he was using a shower chair, but shower chair, shower wheelchair. And then subsequently, because of his current, you know, condition when I saw him, he is not going to need some of the things that I outlined before, because he is not able to use a shower chair now. He will need a shower wheelchair one time. So, I mean, actually it will decrease the price but it's...
Q Okay. Let me make sure --
A I think we are getting a little bit unclear because I haven't done a supplemental report and you are asking me to comment on all these things, what-ifs, and I don't really feel comfortable kind of doing my opinion on the fly like this, because I don't think that that -- I take it very seriously what I do, so I don't want to just...
Q Well, you know what, I actually agree with you because I would have preferred had you done a supplemental report and we can depose you on that as opposed to deposing you on a report that has no basis now because some of the numbers are going to change, but this is the only chance I get to depose you, so I have to depose you today and ask you the questions, including

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what-ifs.
MR. McALPINE: Hold on. Let's go off the record for a second.
THE VIDEOGRAPHER: Yes, sir.
MR. McALPINE: This is sidebar conversation anyway.
THE VIDEOGRAPHER: We are going off --
MR. GREENE: I am not ready to go off the record.
THE VIDEOGRAPHER: Oh, I apologize.
MR. GREENE: I am asking questions.
THE VIDEOGRAPHER: Yes, sir.
MR. McALPINE: All right. Let's read that back and see if that was a question.
MR. GREENE: Well, you interrupted me. You didn't let me finish but --
MR. McALPINE: All right. What's your question?
MR. GREENE: Please read it back.
(THE REPORTER READ BACK THE REQUESTED PORTION OF TESTIMONY.)
Q (BY MR. GREENE) As in --
MR. McALPINE: Objection. Sidebar.
Q (BY MR. GREENE) As in, what if when you do your supplemental report, what about these numbers are

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changed? What are you taking out?
MR. McALPINE: Objection. Too general.
Q (BY MR. GREENE) What services and items are you omitting?
THE REPORTER: I'm sorry. What was your objection?
MR. McALPINE: Too general.
A You want me to go through --
Q (BY MR. GREENE) If you can tell me. I mean, you may not be able to.
A As of right now -- and I will say that if there is a subsequent report, that this may change, but as of right now, I believe he won't need the transfer board, he won't need the reacher, he won't need the shower chair or the... Yeah, that's it.
Q In the whole report?
A No, in this section. I don't have an answer for the rest of the report. I really want --
Q Right. And why doesn't he need those things?
A Because of his comorbidities now.
Q I'm sorry. Because of what?
A Comorbidities now.
Q He had the same -- okay. What are the comorbidities?
A How is he going to use a reacher if he can't

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use his hands? I'm just being common sense about it.
Q Okay.
A Yeah.
Q So are you replacing that with something?
A No.
Q For example, you took the shower chair -- you are going to take it out and replace it with just the shower wheelchair?
A I am not putting anything else. He has the shower wheelchair already, so I don't need to replace it with anything.
Q But this report, the December 1st, 2016, report, it is based on him being a T12 ASIA B, right?
A Yes. And I did have some knowledge of this other accident, but not enough to say -- yeah, I put in what I thought he needed, based on the information that I had.
Q So some of the things that you put in are based on the subsequent accident?
A No.
Q Okay. So, again --
A Not -- not as a -- not as he needs these because now he is a tetraplegic. I am saying I did take it into account that he has it as a comorbidity, for example, you know?

Q You took it into account at the time you wrote the report?
A I was aware of it. I did my very best to make sure that this report reflected that first accident, which is what I was asked to do.
Q But you did take it into account when you wrote this first report?
A Yes, because I knew about it, so I'm not -- I am obviously not going to, you know, include something that I think is ridiculous because of his current situation, you know what I am saying?
Q What's the basis for the transportation allowance?
MR. McALPINE: I think we now know what it is. Go ahead.
MR. GREENE: Apparently, you are the only one.
A What page is this? Sorry. What page?
Q (BY MR. GREENE) I have no idea.
A Oh, transportation --
Q "Environmental modifications and essential services."
A Okay. I am assuming -- at the time I did this report, I am assuming that he will not be completely independent with driving. I wasn't assuming he is not

going to do anything, but I think that he is -- he would need some assistance with being transported to and from doctors' appointments, for example.
Q All right. But at the time you wrote this report, you did not know that he was driving with hand controls, did you?
A Yeah -- I don't know.
Q No, you did not know that. How would you have known that?
A He told me.
MR. McALPINE: Objection. Misstates prior testimony.
A He told me, but I don't know if he mentioned it in the exam form. I will take a look at that if you have it.
Q (BY MR. GREENE) If he was driving -- and he was driving, right? You understand that?
A I'm sorry. Can I take a break?
Q Do you want to take a break?
A Yeah. I'm sorry.
THE VIDEOGRAPHER: We are going off the record at 2:36.
(RECESS FROM 2:36 P.M. TO 2:44 P.M.)
THE VIDEOGRAPHER: Back on the record at 2:44 p.m.

MR. GREENE: So I understand that, Dr. Iversen, you have to leave and we are going to suspend the deposition because of a personal issue with your husband, I think, coming out of surgery. So, obviously, we will suspend the deposition and we will reschedule it.
Mr. McAlpine, with respect to supplementing the report, I have to talk to my client about whether they are willing to allow her to do that or whether we need a hearing on it, but let me talk to them first before --
MR. McALPINE: Since you brought up that issue, I mean, I don't know that it's a consent -- I don't know that you would have -- I mean, you could file an objection, however, we are within the discovery period.
I mean, I know Tim had said something in English's depo about that, but subsequent to that, I had done research and there may be a question if we could supplement a report or supplement expert opinions outside of discovery, but --
MR. GREENE: No. I'm not --
MR. McALPINE: I am not asking you to agree to anything. I'm just saying that we are going to.

MR. GREENE: Right. And I am not arguing with you, but I don't want you to think that, "Oh, they didn't object to it. They didn't" -- "they waived it." I'm just saying --
MR. McALPINE: No, no, no, you haven't waived anything.
MR. GREENE: -- we aren't waiving anything so...
MR. McALPINE: And I'll even --
MR. GREENE: We can talk about this off the record. Let's let Dr. Iversen go.
MR. McALPINE: I will even go so far as to -- okay. Yes, that's fine actually.
MR. GREENE: We are off the record now.
THE VIDEOGRAPHER: We are going off the record at 2:45 p.m.
(DEPOSITION RECESSED AT 2:45 P.M.)
(EXHIBIT 12 WAS MARKED.)

CHANGES AND SIGNATURE

WITNESS NAME: _____

DATE OF DEPOSITION: _____

PAGE LINE CHANGE REASON

I, SASHA R. IVERSEN, D.O., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
SASHA R. IVERSEN, D.O.

THE STATE OF _____)
COUNTY OF _____)

Before me, _____, on this day personally appeared SASHA R. IVERSEN, D.O., known to me (or proved to me under oath or through _____) (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, _____.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF _____
COMMISSION EXPIRES: _____

THE STATE OF TEXAS:
COUNTY OF HARRIS:

I, Mona S. Whitmarsh, a Certified Shorthand Reporter, hereby certify that the foregoing testimony was given before me after the Witness had been first duly sworn.

I further certify that this deposition was transcribed under my direction and is a complete and correct transcript of the proceedings; and that it is being filed with the Court in accordance with the Stipulation of Counsel contained in this deposition.

I further certify that I am neither attorney for, related to, nor employed by any of the parties to the lawsuit in which this deposition was taken. Further, I am neither related to nor employed by any attorney of record in this cause; nor do I have a financial interest in the matter.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this ____ day of _____, 2017.

Mona S. Whitmarsh
Texas CSR No. 3986
Expiration Date: 12/31/17

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